

**Systems of Care  
Promising Practices in Children's Mental Health  
1998 Series**

**VOLUME VI  
PROMISING PRACTICES:  
BUILDING COLLABORATION IN SYSTEMS OF CARE**

**Research and Training for Children's Mental Health  
Louis de la Parte Florida Mental Health Institute  
University of South Florida**

**Authors:**

Sharon Hodges, Ph.D.  
Teresa Nesman, M.A.  
Mario Hernandez, Ph.D.



Child, Adolescent, and Family Branch  
Division of Knowledge Development and Systems Change  
Center for Mental Health Services  
Substance Abuse and Mental Health Services Administration  
U.S. Department of Health and Human Services

**U.S. Department of Health and Human Services**

Donna Shalala

*Secretary*

**Substance Abuse and Mental Health Services Administration**

Nelba Chavez

*Administrator*

**Center for Mental Health Services**

Bernard S. Arons, *Director*

**Division of Knowledge Development and Systems Change**

Michael English, *Director*

**Child, Adolescent, and Family Branch**

Gary De Carolis, *Chief*

*Suggested citation:*

Hodges, S., Nesman, T., and Hernandez, M. (1999). Promising practices: Building collaboration in systems of care. *Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume VI*. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

The writing of all Volumes in the 1998 *Promising Practices* series was funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services. This Volume was written by the Research and Training Center for Children's Mental Health at the University of South Florida, which is supported by the Center for Mental Health Services, as well as the National Institute on Disability and Rehabilitation Research, Office of Special Education and Rehabilitative Services, U.S. Department of Education (grant number H133B90004). Production of the document was coordinated by the Center for Effective Collaboration and Practice at the American Institutes for Research, funded under a cooperative agreement with the Office of Special Education Programs, Office of Special Education and Rehabilitative Services, United States Department of Education, with additional support from the Child, Adolescent, and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Administration, United States Department of Health and Human Services (grant number H237T60005). The content of this publication does not necessarily reflect the views or policies of the funding agencies and should not be regarded as such.

# Table of Contents

---

FOREWORD .....	7
ACKNOWLEDGMENTS .....	9
EXECUTIVE SUMMARY .....	11
CHAPTER I: INTRODUCTION.....	17
CHAPTER II: WHAT THE RESEARCH SAYS ABOUT COLLABORATION .....	21
Introduction .....	21
Why Is Collaboration Important? .....	21
What is Collaboration? .....	24
Are There Different Types of Collaboration? .....	26
What are Common Barriers to Collaboration? .....	28
What are the Components of Successful Collaboration? .....	30
Summary .....	33
CHAPTER III: THE FOUNDATIONS OF COLLABORATION .....	35
Introduction .....	35
Working from Strengths .....	36
Understanding the Challenges of Collaboration .....	39
CHAPTER IV: STRATEGIES FOR IMPLEMENTING COLLABORATIVE PROCESSES .....	43
Introduction .....	43
Structural Elements of Collaboration .....	43
Relationship Building Strategies .....	50
Family and Community Involvement .....	58
CHAPTER V: THE RESULTS OF COLLABORATION .....	63
Introduction .....	63
Improved Relationships Among Child-Serving Agencies .....	63
Reframing Service Delivery Through Systems of Care .....	66
Increased Relevance of Mental Health Services .....	66
Changes in Service Delivery .....	67
Improved Relationships Between Families and Service Providers .....	69
CHAPTER VI: IMPLICATIONS FOR BUILDING COLLABORATION .....	71
Introduction .....	71
Lessons Learned .....	71
Developmental Stages of Collaboration .....	73
Achieving True Collaboration .....	79

## Table of Contents, continued

ENDNOTES .....	82
APPENDIX A .....	91
APPENDIX B.....	97
APPENDIX C .....	101

# List of Exhibits

---

EXHIBIT 1	
Collaboration as a Developmental Process.....	73
EXHIBIT 2	
Developmental Stage 1: Individual Action.....	74
EXHIBIT 3	
Developmental Stage 2: One-on-One.....	75
EXHIBIT 4	
Developmental Stage 3: New Service Development.....	76
EXHIBIT 5	
Developmental Stage 4: Professional Collaboration.....	77
EXHIBIT 6	
Family Involvement as a Developmental Process.....	78
EXHIBIT 7	
Developmental Stage 5: True Collaboration.....	79



# Foreword

---

It is with great pleasure that we present the first collection of monographs from the *Promising Practices Initiative* of the Comprehensive Community Mental Health Services for Children and Their Families Program. The Comprehensive Community Mental Health Services for Children and Their Families Program is a multi-million dollar grant program that currently supports 41 comprehensive systems of care throughout America, helping to meet the needs of many of the 3.5 to 4 million children with a serious emotional disturbance living in this country. Each one of the seven monographs explores a successful practice in providing effective, coordinated care to children with a serious emotional disturbance and their families.

The 1998 Series marks a turning point in this five-year-old federal effort, which is administered by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The first generation of five-year grants is about to come to an end, and with that “graduation” comes a responsibility to add to the national knowledge base on how best to support and service the mental health needs of children with serious emotional disturbance. Until the very recent past, these young people have been systematically denied the opportunity to share in the home, community and educational life that their peers often take for granted. Instead, these children have lived lives fraught with separation from family and community, being placed in residential treatment centers or in-patient psychiatric centers, hundreds and even thousands of miles away from their home. For many of these young people, a lack of understanding of their psychopathology, underdeveloped or non-existing community resources, and a sense of frustration of what to do have led to their eventual placement away from home.

The *Promising Practices Initiative* is one small step to ensure that all Americans can have the latest available information about how best to help serve and support these children at home and in their community. Children with serious emotional disturbance utilize many publicly funded systems, including child welfare, juvenile justice, special education, and mental health, and they and their families often face many obstacles to gaining the care they need due to the difficulties and gaps in navigating multiple service systems. Systems of care provide a promising solution for these children and their families by coordinating or integrating the services and supports they need across all of these public service systems.

The information contained within these monographs by and large has been garnered within the original 31 grants of the Comprehensive Community Mental Health Services for Children and Their Families Program. The research was conducted in a manner that mirrored the guiding principles of the systems of care involved so that it was family-driven, community-based, culturally relevant, and inclusive. Methods for information collection included: site visits and focus groups; accessing data gathered by the national program evaluation of all grantees; and numerous interviews of professionals and parents. Family members were included in the research and evaluation processes for all of the monographs. Two of the papers directly address family involvement, and all of the papers dedicate a section to the family's impact on the topic at hand. The research was drawn from the community-based systems of care and much of the research comes from systems of care with *culturally diverse populations*.

The 1998 *Promising Practices* series includes the following volumes:

Volume I - *New Roles for Families in Systems of Care* explores ways in which family members are becoming equal members with service providers and administrators, focusing specifically on two emerging roles: family members as “system of care facilitators” and “family as faculty.”

Volume II - *Promising Practices in Family-Provider Collaboration* examines the fundamental challenges and key aspects of success in building collaboration between families and service providers.

Volume III - *The Role of Education in a System of Care: Effectively Serving Children with Emotional or Behavioral Disorders* explores sites that are overcoming obstacles to educating children with a serious emotional disturbance and establishing successful school-based systems of care.

Volume IV - *Promising Practices in Wraparound* identifies the essential elements of wraparound, provides a meta-analysis of the research previously done on the topic, and examines how three sites are turning wraparound into promising practices in their system of care.

Volume V- *Promising Practices: Training Strategies for Serving Children with Serious Emotional Disturbance and Their Families in a System of Care* examines theories of adult learning, core values, and four key areas (cultural competence, family-professional relationships, systems thinking, and inter-professional education and training), and looks at promising practices that are combining these concepts into a successful sustainable training program.

Volume VI- *Promising Practices: Building Collaboration in Systems of Care* explores the importance of collaboration in a system of care focusing on three specific issues: the foundations of collaboration, strategies for implementing the collaborative process, and the results of collaboration

Volume VII - *In A Compilation of Lessons Learned from the 22 Grantees of the 1997 Comprehensive Community Mental Health Services for Children and Their Families Program*, the grantees themselves share their experiences in five main areas: family involvement/empowerment, cultural competency, systems of care, evaluation, and managed care.

These seven documents are just the beginning of this process. As you read through each paper, you may be left with a sense that some topics you would like to read about are not to be found in this series. We would expect that to happen simply because so many issues need to be addressed. We fully expect this series of documents to become part of the culture of this critical program. If a specific topic isn't here today, look for it tomorrow. In fact, let us know your thoughts on what would be most helpful to you as you go about ensuring that all children have a chance to have their mental health needs met within their home and community.

So, the 1998 *Promising Practices* series is now yours to read, share, discuss, debate, analyze, and utilize. Our hope is that the information contained throughout this Series stretches your thinking and results in your being better able to realize our collective dream that all children, no matter how difficult their disability, can be served in a quality manner within the context of their home and community. COMMUNITIES CAN!

Nelba Chavez, Ph.D.  
Administrator  
Substance Abuse and Mental Health  
Services Administration

Bernard Arons, M.D.  
Director  
Center for Mental Health Services

# Acknowledgments

---

This *Promising Practices* series is the culmination of the efforts of many individuals and organizations who committed endless hours participating in the many interviews, meetings, phone calls, and drafting of the documents that are represented here. Special appreciation goes to all of the people involved in the grants of the Comprehensive Community Mental Health Services for Children and Their Families Program for going beyond the call of duty to make this effort successful. This activity was not in the grant announcement when they applied! Also a big thank you to all of the writing teams that have had to meet deadline after deadline in order to put this together in a timely fashion. The staff of the Child, Adolescent, and Family Branch deserve a big thank you for their support of the grantees in keeping this effort moving forward under the crunch of so many other activities that seems to make days blend into months. Thanks to David Osher and his staff at the Center for Effective Collaboration and Practice for overseeing the production of this first *Promising Practices* series, specifically: Lalaine Tate for word processing and layout design; Lenore Webb for carefully editing all the manuscripts during the final production phases; Cecily Darden for assisting in editing and proofreading; and Allison Gruner for coordinating the production. Finally, a special thank you goes to Dorothy Webman, who had the dubious pleasure of trying to coordinate this huge effort from the onset. While at times it may have felt like trying to move jelly up a hill, Dorothy was able to put a smile on a difficult challenge and rise to the occasion. Many people have commented that her commitment to the task helped them keep moving forward to a successful completion.

The research and writing team for this project included Dr. Sharon Hodges, Ms. Teresa Nesman, Dr. Mario Hernandez, and Ms. Angela Gomez. All members of the project team serve on the faculty and staff of the Department of Child and Family Studies at the Louis de la Parte Florida Mental Health Institute, at the University of South Florida in Tampa. This project benefited by the research and technical support of two graduate assistants: Ellen Puccia and Nichole Spaulding, both students in the Department of Anthropology at the University of South Florida.

In addition, this project benefited from the input of two outside readers: Karen Hart with United Advocates for Children of California, and Susan Mallory, a consumer advocate and member of the Hanover County (Virginia) Community Service Board. These readers were not involved in the project design for this study or the data collection and analysis. They were asked to read the monograph and provide critical feedback when it was in draft form as an effort to ensure clarity, completeness, and its ability to speak to the issues and needs of families as well as the service provider community. Their assistance is very much appreciated.



# Executive Summary

---

## INTRODUCTION

This monograph was developed for the purpose of describing promising practices in interagency collaboration at sites funded by the federal Center for Mental Health Services as part of the Comprehensive Community Mental Health Services for Children and Their Families Program. Traditionally, services for the

---

*The benefits of collaboration far outweigh the investment it requires in time and energy.*

---

estimated 3.5 million children and adolescents in the United States who are affected by serious emotional disturbance have been delivered categorically by individual agencies, leaving the service delivery system fragmented, costly and often

unavailable to those most in need. Interagency collaboration, the process of child-serving agencies joining together for the purpose of improving services, represents a fundamental reform in the way services to children with serious emotional disturbance and their families are delivered.

The nine sites participating in this study are actively building collaborative processes into their service delivery systems. In spite of the differences in mandate, funding and structure among child-serving agencies, these sites have found the benefits of collaboration far outweigh the investment it requires in time and energy.

- They are finding that collaboration helps bridge the complexities of their work, allowing them to be more responsive and effective. As one respondent commented, "Partnerships aren't a luxury, they're essential because the problems are too big and too complex."
- They are finding that when child-serving agencies focus on the needs of children and families that the agencies share more similarities than differences. As another respondent observed, "the bottom line ... is that there is no distinction; the needs of children and families [in different agencies] are not significantly different."
- And they are finding that collaboration produces results. Not only are relationships improved among child-serving agencies, but the services they offer are more individualized, less restrictive and anchored in their community. Another respondent, commenting on a documented 48 percent reduction in out-of-home placements that is attributed to their collaborative efforts, made the observation, "Collaboration works for kids and families. And it is cost effective."

---

*"Collaboration works for kids and families. And it is cost effective."*

---

Although the sites in this study spoke of their efforts to build interagency collaboration, many referenced “true collaboration” as their real mission. True collaboration is distinguished from collaboration based on rules and mandates that exists in name only. The sites described true collaboration as embodying:

- role clarity for families and service providers;
- interdependence and shared responsibility among collaborating partners;
- striving for vision-driven solutions; and
- a focus on the whole child in the context of the child's family and community.

This study investigates the experience of service providers, administrators, families and community members involved in the Comprehensive Community Mental Health Services for Children and their Families Program as it relates to their efforts to establish collaborative practice in their service delivery system. The study and its findings are described in more detail below.

## **STUDY DESIGN**

This study began with a preliminary review of literature about collaboration which pointed out why there is a need for collaboration; summarized attempts to define, characterize and create a framework for collaboration; described common barriers to the process; and described components of successful collaboration. The literature review helped to shape the questions used to interview participants at each of the sites for the purpose of defining, describing, characterizing and creating a framework to describe the process of collaboration at each site.

Ninety-eight interviews were conducted by phone or in person in order to capture participants' experiences, successes, hopes and concerns for collaborative practice. Respondents included service providers, administrators, families and community members. Participating sites were chosen to reflect the variety of contexts in which systems reform is occurring, including rural, small counties and urban sites. Five questions guided this research:

- What are the components of strong and effective collaboration?
- What structural and relational factors contribute to increased collaboration?
- How has increased collaboration changed service to children and families?
- What supports and impediments have been experienced in building collaboration?
- Has collaboration changed the way stakeholders perceive children's mental health?

## **FINDINGS**

The findings of this study have been clustered into three categories: 1) the foundations of collaboration; 2) strategies for implementing collaborative processes; and 3) the results of collaboration. These clusters represent individual chapters in this monograph and are summarized below.

*The Foundations of Collaboration* section provides context surrounding early efforts to build collaborative practice. The foundations chapter includes a discussion of strengths upon which collaboration has been built; these include the desire to change and the emergence of strong leadership. This section also presents the challenges faced in building collaboration; these include blame and distrust among child-serving agencies, inflexibility and the fear of change.

*The Strategies for Implementing Collaborative Processes* section focuses on the strategies that were identified by the sites as the most promising tools for building collaborative practice. These strategies are grouped into three broad categories: 1) structural elements, which include cross-agency governance, formal collaborative groups at supervisory and service levels, formal interagency agreements and collaborative specific staff, the availability of a pool of funds for flexible use, and a commitment to group decision making and joint problem solving; 2) relationship-building strategies, which include starting with a small core group and building strategically from that point, recognizing strengths and limitations of participating agencies, nurturing collaboration by creating win-win situations, providing opportunities for informal networking such as retreats, exerting peer pressure to urge collaboration and encouraging innovation and risk; 3) engaging families and the community in collaborative processes, which includes strategies for increasing the participation of families in service planning and delivery as full partners both at the system level and at the individual case level, and tying the mission and goals of the collaborative to local community issues and concerns.

*The Results of Collaboration* section identifies positive results of collaboration that can be clustered into five broad categories: 1) improved relationships among child-serving agencies; 2) increased understanding of system-of-care principles; 3) increased relevance of mental health services; 4) improved service delivery; and 5) improved relationships between families and service providers.

## THE IMPLICATIONS FOR BUILDING COLLABORATION

This study of collaboration offers the opportunity to consider implications for building collaborative processes in other communities that are striving to build systems of care for children with serious emotional disturbance and their families. The implications of this study can be summarized in three broad statements about the process of building interagency collaboration.

- Collaboration must occur at multiple administrative levels within a child-serving agency and across the multiple agencies that provide services for children and families.
- Building collaboration is a developmental process that takes time and considerable effort.
- The emergence of families as full partners in systems of care is the key to true and lasting collaboration.

---

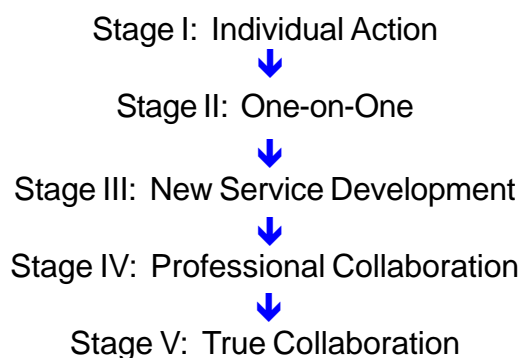
*The emergence of families as full partners in systems of care is the key to true and lasting collaboration.*

---

**Multi-level participation in collaborative efforts.** Feedback from the sites participating in this study emphasized the necessity of involving multiple levels of agency personnel in collaborative efforts. Three levels of involvement were identified: agency-level participation, usually involving agency heads in collaborative activity; program-level participation, involving the mid-level managers who direct programs and services; and practice-level involvement for the purpose of ensuring that collaboration is established in the context of day-to-day service delivery.

**Collaboration as a developmental process.** As the sites involved in this study described their experiences in building interagency collaboration, they emphasized the developmental nature of this process. Five stages of development were identified as part of this process, each having defining characteristics and

### Collaboration as a Developmental Process



collaborative activities associated with that stage. Although the sites described their movement through these stages as uneven rather than linear, the stages illustrate the move away from individual action and toward collaborative processes.

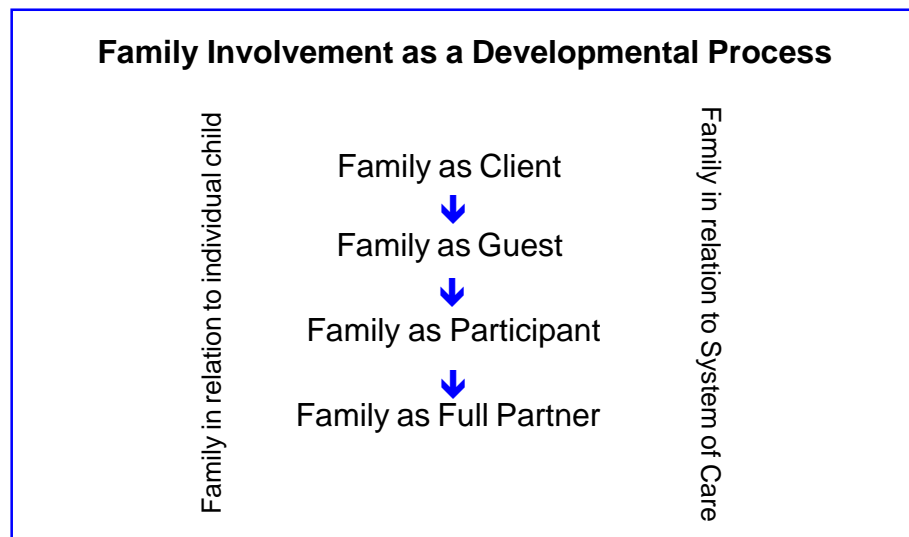
---

**R**espondents indicate that family involvement ensures a constancy and consistency in collaborative efforts regardless of administrative, staff and funding changes that affect all child-serving agencies over time.

---

**Families as full partners.** Alongside this model of collaboration as a developmental process is a description of the stages of family involvement in the process of collaboration, beginning with families being viewed as clients of the system of care and progressing to the involvement of families as full partners. The stages of development illustrate a move away from considering family members as outsiders to the service delivery

process and toward involving families in a collaborative effort. Participants in this study report that this is an uneven process of development and that successfully involving families in decisions that affect service design and policy does not assure family involvement at the level of the individual child.

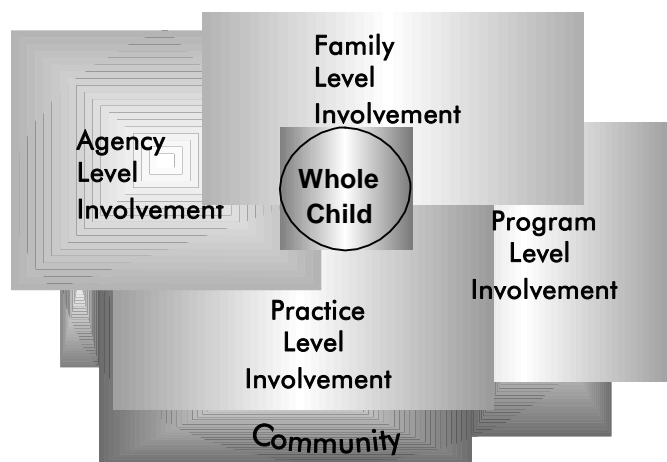


## TRUE COLLABORATION

The results of this study indicate that the developmental process of interagency collaboration must be interwoven with the process of developing the participation of families as full partners in their system of care and that family involvement must occur at all three levels of interagency collaboration: the agency level, the program level and the practice or direct service level. It is through the emergence of the family as full

partner in a system of care that true collaboration can be achieved. The figure on the next page illustrates the four essential components that come together around the whole child for the purpose of improving services for children with serious emotional disturbance.

### **Essential Components of True Collaboration**



Sites that have begun to involve families as full collaborative partners have come to believe that families are the key to sustaining their collaborative efforts. Respondents indicate that family involvement ensures a constancy and consistency in collaborative efforts regardless of administrative, staff and funding changes that affect all child-serving agencies over time. Respondents also indicate that family involvement makes the service system accountable to the family and community in ways that would not otherwise be possible.

# Chapter I

## Introduction

---

Interagency Collaboration — the process of agencies joining together for the purpose of interdependent problem solving that focuses on improving services to children and families — represents a fundamental reform in the way services are provided for children with serious emotional disturbance and their families. Traditionally, services for the estimated 3.5 million children and adolescents in the United States who are affected by serious emotional disturbance have been fragmented, costly, overly restrictive, frequently provided outside of the children's home communities, and very often unavailable. New and innovative models of service delivery that are built upon the principles of a system of care offer community-based services that are family-centered and culturally competent.

These new approaches to service delivery require more than the coordination of services and more than cooperation between individual agencies. The Comprehensive Community Mental Health Services for Children and Their Families Program, funded by the federal Center for Mental Health Services, has funded sites to plan and implement systems of care for children and families. A system of care approach to services for children with serious emotional disturbance maintains that service delivery is not the responsibility of a single agency, but should involve a collaborative network of child-serving agencies that includes mental health, child welfare, education, juvenile justice, and other appropriate services. Overcoming the traditional fragmentation in services for children with serious emotional disturbance cannot be accomplished without “true collaboration” among child-serving agencies. The system of care approach to service delivery provides for a comprehensive spectrum of mental health and other support services organized into a collaborative network for the purpose of meeting the multiple and changing needs of children, adolescents and their families.

The phrase “true collaboration,” as distinguished from collaboration based on rules and compliance that exists in name only, was referenced repeatedly by the participants in the federal Center for Mental Health Services (CMHS) Comprehensive Community Mental Health Services for Children and Their Families Program who were interviewed for this study. True collaboration is *successful* collaboration, as experienced by collaborative participants, that incorporates qualities of role clarity for families and service providers, interdependence and shared responsibility among collaborating partners, striving for vision-driven solutions and a focus on the whole child in the

context of the child's family and community. True collaboration is the mission of these sites, and improved service to children and families is their goal. But true collaboration is difficult to achieve because it is both the process and product of building systems of care. A well-developed system of care generates collaborative practice among child-serving agencies, but a system of care cannot be developed without collaboration as its underpinning. Collaboration both creates and supports itself. True collaboration breeds more collaboration and true collaboration is at the heart of a system of care.

The reform required to build such a collaborative network of services is regarded as nothing short of revolutionary by those involved in the process. A respondent in Rhode Island described the process of building a system of care by saying, "What we're doing is a revolution in consciousness and a revolution in practice." True collaboration requires that agencies shift from thinking of the children they serve as "my children" to thinking in terms of the system of care responding to "our children." It requires shared decision making and shared responsibility among child-serving agencies. And it requires a continued focus on what is best for individual children and families in the context of their community.

---

*The reform required to build such a collaborative network of services is regarded as nothing short of revolutionary by those involved in the process.*

---

Building collaboration and creating changes in service delivery that are as profound as these takes time. In a world focused on short-term gain, it is difficult to measure and value progress and success in terms of the long run. Not one site participating in this study felt their work was complete. At sites where collaborative efforts had begun, the Comprehensive Community Mental Health Services for Children and Their Families Program, funded by the federal Center for Mental Health Services, provided the opportunity to expand collaboration and anchor it more firmly in their systems of care. At sites just beginning the process of building a system of care, the CMHS grant provided a platform for initiating collaborative practice. The results of this study demonstrated that each site has made significant progress toward improving services for children and all look forward to continuing their work. These sites generously offered the knowledge they have gained in building collaborative processes so that others might learn from their experiences.

Nine of the Comprehensive Community Mental Health Services for Children and Their Families Program sites participated in this study: the *East Baltimore Mental Health Partnership*; *KanFocus* in Kansas; *New Opportunities* in Lane County, Oregon; the *Pitt-Edgecomb-Nash Public Academic Liaison (PEN-PAL) Project* in North Carolina; the *Resources Effectively Allocated for Children Project*

(Project REACH) in Rhode Island; San Mateo and Ventura County Child and Youth Systems of Care in California; Stark County, Ohio; and *Access Vermont*. A brief description of these sites is provided in Appendix A.

The goal of this Promising Practice monograph was to learn from the experience of service providers, administrators, families and community members at these sites regarding their experiences, successes, hopes and concerns for collaborative practice so that others might benefit from their experience. Ninety-eight interviews were conducted as part of this process. The semi-structured interview process was guided by five research questions:

- What are the components of strong and effective collaboration?
- What structural and relational factors contribute to increased collaboration?
- How has increased collaboration changed service to children and families?
- What supports and impediments have been experienced in building collaboration?
- Has collaboration changed the way stakeholders perceive children's mental health?

In addition to the interview process, the sites participating in this study provided clarification and correction to the data by participating in a validation process. Data summaries for each site were returned to the site and interview participants were asked to provide feedback by making clarifications and corrections to the site data. In addition, each site received a draft of this monograph for review prior to publication.

This study also benefited from a review by two outside readers who were not involved in the research design or data collection and analysis. They are Karen Hart with United Advocates for Children of California, and Susan Mallory, a consumer advocate and member of the Hanover County (Virginia) Community Service Board. Their input is most appreciated.

A more detailed description of the methods used in the data collection and analysis for this study are provided in Appendix B.

Child-serving agencies in North Carolina's *PEN-PAL Project* commented that building collaboration is not a program and it is not a project. Instead, they emphasized that it is a process that represents "a new way of doing business." This refrain, collaboration as a process, was echoed throughout the sites participating in this study. The monograph that follows describes the process of building collaboration from the perspectives of the nine sites participating in this study. It begins

with a look at what the research says about collaboration — why it is important, how it can be defined, common barriers to collaboration and components of successful collaboration. The three sections that follow this literature review describe the experiences of the nine sites participating in this study with regard to the foundations of their collaboration, their strategies for building collaboration and what they have experienced as the most important results of collaboration. The monograph concludes with a discussion of these results.

# **Chapter II**

## **What the Research Says about Collaboration**

---

### **INTRODUCTION**

There is a lot of talk about collaboration within the child-serving agencies that provide services to children with serious emotional disturbance and their families. Collaboration, collaborative practice, and collaborative processes are phrases that surface often in discussions of how to improve services to children and families. Family members, service providers, and administrators are struggling to understand what collaboration really is, why it's important, and what the common steps in building collaboration are.

Because of the interest in collaboration, much has been written on the topic. This chapter will review what the research tells us about collaboration and the process of building collaborative practice. Specifically, this section will consider:

- Why collaboration is important
- How collaboration is defined
- Different types of collaboration
- Common barriers to collaboration
- Components of successful collaboration

### **WHY IS COLLABORATION IMPORTANT?**

The guiding principles to a system of care<sup>1</sup> tell us that our service delivery systems should be child- and family-focused and that services should be comprehensive, coordinated, community-based, culturally competent and individualized. Achieving these goals is a challenge for service systems that have traditionally worked independently and autonomously of one another. Working collaboratively is believed to be a key ingredient and driving force in developing systems of care to serve children with serious emotional disturbance and their families.

The need for collaboration in systems of care has been driven by forces at every level, from national to state to community to agency and family levels. These forces have included the changes in funding that have come about because the move toward managed care has demanded reductions in the duplication of services and increased efficiency and accountability.<sup>2</sup> At the national level, federal initiatives looking for the development of new treatment strategies have also included collaboration as a necessary component. At the state level, policy makers are calling for interagency collaboration in order to decrease spending and improve outcomes. At both the state and the community level, demands from interagency planning groups can be overwhelming to agencies that are not already working collaboratively. At the local level, collaboration is sometimes driven by negative publicity and court action, such as court orders to form interagency groups in an effort to force service providers to better meet the needs of children with serious emotional disturbance.<sup>3</sup> Even at the direct service level, programs are being created that attempt to overcome differences in service delivery strategies and philosophies by incorporating systems of care philosophy into in-service and pre-service training. And all of this is bolstered by increased parent and family demands for quality, accessibility and appropriate services, along with a push for consideration of the family's perspective in service planning and delivery.

In response to the need to change service delivery to include system-of-care principles, strategies have been developed that include interagency collaboration as well as related actions of planning and needs assessment, system modifications to fit identified needs, technical assistance and training and constituency building.<sup>4</sup> Documented advantages of implementing such strategies in systems of care have included cost efficiency for the desired outcomes and improved advocacy for children's mental health.<sup>5</sup>

Incorporating collaboration into systems of care has been found to be most effective when implemented at all levels. In such a system, parents and families are listened to and staff, supervisors and administrators across agencies are more aware of the negative effects of compartmentalization of services and differences in eligibility criteria on the children served.

The research shows that collaboration at all levels can lead to improved access and tracking of services through coordination or integration at administrative levels and reduction in barriers for families at service levels.<sup>6</sup> In addition to increased access to services, cross-level collaboration can also lead to improved quality of services through the involvement of supervisory personnel.<sup>7</sup> For individual agencies, collaboration can result in the expansion of resources available through cooperative programming, enhancement of staff skills by sharing information and organizing joint training, and sharing facilities and

staff.<sup>8</sup> The process of collaboration can also change the way agencies are perceived by the community through demonstrating improved outcomes, increased client satisfaction, and increased savings due to reduction of unnecessary duplication of services.<sup>9</sup>

At the system or community level, collaboration can benefit a greater array of children through development of a wider picture of the needs of the community as agencies create a common vision and develop a comprehensive plan for local intervention.<sup>10</sup> In addition, interagency collaboration can address complex problems from a variety of perspectives and reduce the likelihood of placing undue responsibility or blame on any one agency.<sup>11</sup> Such collaboration can also lead to improved mutual understanding of agencies' constraints and thus improved relations between participants.<sup>12</sup>

The formation of formal structures and agreements in collaboratives can lead to changes in agency policies, rules and regulations so that there is improved cooperation, better coordination of services, and quicker decision-making.<sup>13</sup> This can help to break down old bureaucracies, decrease competition and ease the formation of collaborative networks and informal relationships among various agency staff.<sup>14</sup> For example, placement of a collaborative program in the hands of a formal community mental health services board in one community resulted in a shift in focus from an individual psychotherapy approach to a family- and community-based approach in children's mental health.<sup>15</sup>

Collaboration can also provide greater visibility for issues, challenges and successes of services for children with serious emotional disturbance and a greater voice by collective advocacy with decision makers, the media and the community.<sup>16</sup> Interagency collaboration has led to awareness of the constraints and pressures each agency experiences at both state and community levels.<sup>17</sup> This can result in changes in policies that allow for more flexibility in adjusting services at the local level to local needs, creating funding incentives for community collaboration efforts and providing technical assistance and evaluation support from larger state or county offices.<sup>18</sup> The issue of top-down directives versus community flexibility in planning has been addressed by some systems of care through an ongoing evaluation-stakeholder feedback loop between local interagency management teams which make decisions about local services and evaluation information provided by a state-level evaluation office.<sup>19</sup>

As financial resources become more scarce and stakeholders demand greater accountability, states and communities feel increasing pressure to find common goals, pool resources, and become responsible for common outcomes.<sup>20</sup> Both the complexity of the needs of children and youth with serious emotional disturbance and rising expectations of stakeholders are motivators to seek collaboration at all levels in order to use funds more efficiently and provide appropriate services.<sup>21</sup>

## **WHAT IS COLLABORATION?**

### **Definition**

Collaboration in systems of care can be defined as the process of bringing together those who have a stake in children's mental health for the purpose of interdependent problem solving that focuses on improving services to children and families. This definition recognizes that the goal of collaboration is the establishment of a process for problem solving, rather than an end result in itself.<sup>22</sup> The process has been described as one in which participants "...join forces, pool information, knock heads, construct alternative solutions and forge an agreement."<sup>23</sup> Collaboration requires willingness of participants to acknowledge their interdependence and to share "risks, resources, responsibilities and rewards."<sup>24</sup> This interdependence also leads to a level of commitment that is necessary to design a formal framework for problem solving, in contrast to a cooperative relationship between agencies that is short-term and lacks joint rules and responsibilities.<sup>25</sup> Focusing on the child and family maintains the vision and commitment of the collaboration to meet the challenge it has set out to address and minimizes competition and turf battles among agencies.<sup>26</sup>

Collaboration is distinguished from coordination or partnership, which shares resources and leadership to address a common issue but does not have an interdependent system with formal roles and responsibilities.<sup>27</sup> Likewise, collaboration is not the same as a temporary coalition formed in response to a specific community problem, but goes beyond being problem-driven to being vision-driven.<sup>28</sup> Collaboration is not just communication, but does require highly developed communication to reach goals that cannot be achieved by acting singly.<sup>29</sup> In contrast to other group endeavors, collaboration implies a structure with by-laws and procedures, a style of work and a sense of community among members, who complement and support one another's efforts.<sup>30</sup> In sum, collaboration is not the end goal, but is an effective means to reach a goal, such as the provision of more comprehensive and appropriate services for children and families.<sup>31</sup>

## **Elements of Collaboration**

The collaborative relationship may be divided into three stages: 1) the beginning stage, when the collaboration is forming and making plans; 2) the growth stage, when plans are implemented into programs and policies; and 3) the evaluation stage, when results are examined and decisions are made about whether or not to make changes.<sup>32</sup> Elements of collaboration may be specific to one stage or continue to develop and change throughout the process.

### **The Formative Stage**

During the formative stage of the collaborative relationship, the research suggests that common goals must be identified by participants and a common vision agreed upon.<sup>33</sup> It is at this time that expertise, resources, information and power need to be shared in order to establish trust and create a plan that is beneficial to everyone involved.<sup>34</sup> There are instances when a shared activity, such as grant proposal writing, has helped to develop collaboration among participants. An example of this is one community's shift in orientation from an individual case focus to a system building focus due to the involvement of agency executives in writing a grant proposal.<sup>35</sup> Other elements in the formative stage include the establishment of a formal structure of policies and procedures and setting up a schedule for regular meetings of participants to address policies and funding responsibilities and to resolve conflicts.<sup>36</sup>

### **Implementation Stage**

During implementation of collaborative plans and programs, a shared style of work and a sense of community are established, involving both formal and informal relationships within and across agencies.<sup>37</sup> This leads to broad-based commitment at all levels and opens the door for change in agency policies, budgets, and mandates.<sup>38</sup> Some researchers suggest that in order for this to occur, participants in the collaboration process must be able to work independently of their agency loyalties and have authority to implement policy changes that would strengthen collaboration.<sup>39</sup>

### **Evaluation Stage**

During the evaluation stage, collaboration leads to shared responsibility for outcomes and for the future direction of the system of care.<sup>40</sup> This means that, by tracking services across agencies, the identification of where children are falling through the cracks can be addressed as a system-wide problem.<sup>41</sup> In addition, resources can be identified and used in new ways, with the advantage of

expertise from various disciplines and perspectives.<sup>42</sup> Jointly planning, implementing, and evaluating a system of care also creates joint ownership of decisions during continual readjustment to environmental changes and mid-course corrections.<sup>43</sup>

Both process and outcome evaluations are helpful for building and demonstrating the effectiveness of a collaboration.<sup>44</sup> For example, outcome evaluations can be used to document how flexible funds are spent and demonstrate the cost effectiveness of community-based services established through collaboration.<sup>45</sup> Process evaluations can look at how the collaboration is functioning by considering such areas as: the quality of solutions generated by the collaboration, the range of agencies involved, the amount or type of shared information and quality of that communication, the effectiveness and accessibility of service coordinators, the fidelity of the implementation of services to the treatment plan, the types of cases not accepted and the degree and quality of family involvement in the collaboration.<sup>46</sup>

Outcome evaluations can also be used to determine the effectiveness of the collaboration in achieving its overall mission and goals. These evaluations may look at variables such as maintenance in the community (whether or not there are reductions in the number of children in out of home placement, success of transition of children brought back to the home community, amount of recidivism), school success measures (academic progress, suspensions, dropout, behavior rating scales), community-based measures (number and type of community based services used, average time to appropriate placement, number of children entering juvenile detention) and cost effectiveness measures (comparing average cost of services before and after interagency collaboration, cost avoidance).<sup>47</sup> Such evaluations are used by collaboratives to demonstrate to policy makers and top level agency administrators that funds are being used efficiently while providing services that are accomplishing desired outcomes.<sup>48</sup>

## **ARE THERE DIFFERENT TYPES OF COLLABORATION?**

Collaboration exists at various levels and in various forms, depending upon the context. Some researchers describe levels of collaboration in terms of agency hierarchy, such as: 1) interagency or administrative level collaboration, which functions in coordinating services; 2) interagency collaboration at the service level, which creates the network needed to carry out these services; 3) intra-agency collaboration, which involves the participation of all levels within an agency; and 4) worker-family collaboration, which creates a partnership with families to create individualized treatment plans.<sup>49</sup> Researchers point out the importance of considering the need for

collaboration at all of these levels. Involvement at all levels in collaboration results in local level interagency planning, funding, managing and operation of the system of care and promotes flexibility, such as the division of services and funding according to function rather than by provider agency.<sup>50</sup>

Interagency collaboration has also been described by researchers as case-centered, program-centered and policy-centered.<sup>51</sup> Case-centered collaboration addresses the needs of individual cases through case management and case coordination. Program-centered collaboration efforts aim to coordinate previously fragmented services into a comprehensive service system. Policy-centered interagency collaboration involves meetings between representatives from agencies and organizations at state or national levels to advise, plan or recommend policy changes.<sup>52</sup> These task-focused classifications can cut across the four levels mentioned above.

In addition, collaborative efforts have been classified by structural or decision-making characteristics, such as ad hoc or ongoing committees, informal or formal interagency agreements and communication, open membership that recruits new members versus closed membership and outward-directed problem solving versus an inward-directed group focus.<sup>53</sup> Collaborative efforts might include a combination of these characteristics and change over time; for example, one collaborative system of care was born out of an ad hoc planning committee formed in response to a court order mandating interagency coordination, but over time evolved into a formal interagency structure.<sup>54</sup> These changes in structure over time suggest that there may exist stages in a developmental process.

Other descriptions of types of collaboration include a focus on service models such as the system of care model; an individualized care model with wraparound services, flexible funding and unconditional care; and a co-location of services model.<sup>55</sup> System of care models have focused on increasing community-based interagency services by pulling together key personnel from various agencies in collaborative efforts, as was described earlier in this section.<sup>56</sup> Alternatively, the individualized care and wraparound services model places an emphasis on developing individual case planning, monitoring, program development, and flexible funding.<sup>57</sup> The co-location of services model focuses on providing mental health and other services at one location, such as a school, often with the formation of an interagency cooperative agreement.<sup>58</sup> Again, collaboratives may incorporate aspects of any or all of these models in their implementation of collaboratively planned services.

Collaboration has also been described in terms of the level of state and local involvement. This description includes stages of development, which are identified as: 1) the first generation, which includes primarily top-down state mandated structures and principles; 2) the second generation, which includes local demonstration sites supported by state technical assistance and financial incentives; and 3) the third

generation, which includes comprehensive implementation with state support, development of common definitions and eligibility criteria and the provision of joint databases, oversight and evaluation by the state.<sup>59</sup> These stages may also be overlapping, such as establishing a top-down structure while simultaneously trying to maintain sensitivity to local needs and preferences through the creation of community multi-stakeholder coordinating councils.<sup>60</sup>

Other researchers have focused on describing the level of relationship development among community collaborators. These levels include: 1) networking, 2) cooperation or alliance, 3) coordination or partnership, 4) coalition, and 5) collaboration. According to this classification, as communities move through the levels, the purpose for the collaborative relationship becomes more focused and more formalized, with a common vision, shared resources, shared decision making and a shared budget, increased commitment, more formalized roles and work assignments and highly developed communication.<sup>61</sup>

As indicated by these various classifications of types or levels of collaboration, there is a great deal of variation in how collaborations can be described. The development of a comprehensive model of collaboration for systems of care would be helpful in understanding how these classifications fit together. This is an area that requires more research and analysis, especially to identify common elements at each level of collaboration and common elements for collaborations in specific contexts.

## **WHAT ARE COMMON BARRIERS TO COLLABORATION?**

Barriers to collaboration described in the literature might be categorized as personal, systemic, or environmental. A fundamental personal barrier mentioned is the American ethos of competition and independence that works against collaborating with others, promotes turfism, and leads to fear of losing power.<sup>62</sup> Fear may also exist because of the possible loss of funding, redefinition of job responsibilities, loss of identity or autonomy, and negative past experiences with collaboration.<sup>63</sup> For example, a history of adversarial interactions between agencies or individuals can hinder the collaboration process.<sup>64</sup> Staff can feel threatened by pressures toward shared decision making because it decreases their autonomy as professionals or because of differences in treatment philosophy, goals or procedures.<sup>65</sup> In some cases incompetence will be exposed when there is interagency collaboration and this becomes a threat to staff as well as agencies.<sup>66</sup> There may also be differing expectations for the collaboration process and/or differing norms and values about cooperation that lead to a lack of trust among participants.<sup>67</sup>

System-level barriers may include limited resources such as time, specialized staff, technology, funding, and experience with collaboration.<sup>68</sup> Some researchers suggest that collaboration requires coordination of complex joint projects and therefore requires specialized skills and planning apart from that of individual agencies.<sup>69</sup> This process may threaten established ways of doing business and require staff time that takes them away from their normal duties.<sup>70</sup> This potential barrier might be avoided by including in interagency planning the position of service coordinators, whose job description includes maintaining good interagency relationships. To facilitate this, coordinators can be given particularly low case loads so that they can devote enough time to these activities.<sup>71</sup>

Other types of barriers are related to bureaucratic constraints that tend to maintain the status quo, such as standard operating procedures, established incentives, and supervisory control.<sup>72</sup> For example, a disagreement over supervisory control in a collaborative program can result in having to change program structures in order to maintain individual autonomy and power.<sup>73</sup> Some suggest that as old management structures are maintained, agency turfism persists, funding sources are guarded, and eligibility requirements are emphasized, that results in decreased pooling of resources and decreased provision of joint services.<sup>74</sup> In addition, a power disparity among stakeholders can lead to differing perceptions of the risks involved in collaboration, so that those who are more powerful tend to participate less because they believe they have more to lose when resources are shared.<sup>75</sup> Other organizational barriers may include agency cultures and staff role definitions that are segmented by disciplinary lines such as social work, psychology, or education, rather than by services provided such as counseling.<sup>76</sup>

Lack of consensus and lack of communication among agencies is another area of hindrance to collaboration. Lack of adequate communication can be due to differences in the language used to describe the target population and agency roles and can lead to misunderstandings about responsibilities.<sup>77</sup> This can be reinforced when there are different eligibility criteria and funding is categorized by agencies rather than by functions or services.<sup>78</sup> Lack of training or experience in collaboration maintains this segmentation of thinking and acting and can lead to the avoidance of specific and formalized agreements for action.<sup>79</sup> Effective communication and action can also be hindered by lack of authority or commitment on the part of agency representatives who participate in collaboration, or lack of a shared history due to high turnover rates.<sup>80</sup>

Confidentiality is an issue that has had to be addressed by many collaborative efforts. Regulations protecting the privacy of individuals have resulted in a variety of rules governing the sharing of information and release of records among the different types of agencies that comprise systems of care. These regulations are intended to protect the rights of families and children, and therefore may be sidestepped by involving family members in the process of collaboration and gaining permission for generic record release.<sup>81</sup>

Some procedures to address problems of confidentiality have included clarification of reasons for sharing information, identification of legal and ethical issues and addressing them at each agency, and developing a common release form.<sup>82</sup>

Environmental factors at the community, state and national levels can also act as barriers to collaboration. At the community level, barriers may include factors such as racial or cultural polarization, which leads to distrust and lack of communication.<sup>83</sup> State-level factors such as competing mandates for each agency or insufficient resources allocated with the mandate to collaborate can also serve as barriers.<sup>84</sup> The political context may also cause variations in the degree of state control, priorities and resource allocation, such as in fragmented funding streams that do not reimburse for time spent in the collaboration process.<sup>85</sup> If collaboration is imposed upon local communities from the top down, it can be seen as intrusive, counterproductive, and insensitive to local needs and preferences.<sup>86</sup> In addition, there are societal-level dynamics such as periods of zero sum growth, that can create pressures and challenges to collaboration.<sup>87</sup>

## **WHAT ARE THE COMPONENTS OF SUCCESSFUL COLLABORATION?**

### **Shared Goal or Vision**

According to studies of collaboration, collaborative relationships require that the agencies involved spend time cultivating a shared goal or vision.<sup>88</sup> The establishment of a shared goal or vision has been found to be difficult because these shared goals may be different from those of the individual participating agencies.<sup>89</sup> Once an objective is established, however, it can drive all other elements of the collaboration process.<sup>90</sup> Of course, this is only the first of many agreements that the collaborating agencies must make during the course of their working relationship.

### **Speaking the Same Language**

People involved in collaboration must be speaking the same language before agencies can come to many agreements.<sup>91</sup> Because agencies may represent different disciplines such as juvenile justice, mental health and/or public education, each will tend to use discipline-specific jargon, that may hinder the members of the collaborative enterprise from understanding each other. Therefore, collaborations must develop a shared method of communication early in the process, so that differing terminologies do not get in the way of participants recognizing their common goals.<sup>92</sup> An example of a strategy for building a common language is the requirement that members use the language style of other types of agencies; for example, when conversations center around issues of justice, the participants are asked to think in terms of the “language of

care,” and when discussions are focused on psychological concerns, the participants are asked to think in terms of the “language of justice.” This helps the members of the collaborative to respect the views of the other individual agencies involved.<sup>93</sup> A common language is also seen as the first step in the creation of a shared sense of community that will surround the collaborative process. This sense of community is thought to be an important factor in the cultivation of a team loyal to the collaborative.<sup>94</sup>

## **Trust and Commitment**

The establishment of a team whose members trust one another has been found to be an important indicator of success in collaboration.<sup>95</sup> It is suggested by some researchers that trust and commitment to the collaborative project are foundational and may be developed by ensuring that the goals of the collaborative are relevant to each of the individual goals of the participating agencies.<sup>96</sup> Others add that this self-interest should be balanced with commitment to an overarching cause that may sometimes mean allowing loyalty to the collaborative to come before the loyalty felt toward the individual agency where the person works.<sup>97</sup> On the other hand, this balance needs to be realistic on the part of all participants, acknowledging agency loyalties and responsibilities as well as resource availability and constraints.<sup>98</sup>

## **Maintaining Autonomy**

Cooperation is the key to working in a collaborative. One strategy for maintaining cooperation is to limit the number of participating agencies so that splinter groups are not formed.<sup>99</sup> When agencies join the group they need to feel that they can still make decisions independently. Early in the relationship it is helpful to talk about how to maintain autonomy, so that people feel comfortable with participating.<sup>100</sup>

## **Respect for Diversity**

Equality in decision making and voicing of opinions and perspectives must be maintained in the collaborative process.<sup>101</sup> This means that the unique talents and resources each participant brings to the group are valued in working together to accomplish common goals. A respect for diversity opens the door for new attitudes toward change and consideration of new possibilities,<sup>102</sup> particularly if members are invited from previously under represented groups, especially families of children served by the system of care.

## **Clear Roles and Responsibilities**

It is very important for members of any collaborative team to decide who is responsible for the completion of specific duties.<sup>103</sup> To keep peaceful relations in a collaborative, tasks should be equally distributed.<sup>104</sup> Equality in responsibility for the success or failure of a program is also important.<sup>105</sup> In addition, roles should be complementary without being duplicated, so that group members are able to see how they fit together as well as recognize their importance to the collaborative.<sup>106</sup> The development of clear definitions of both individual roles and team roles has also been seen as instrumental in the creation of a “collaborative team.”<sup>107</sup> This is a pivotal first step in fostering a sense of loyalty to the collaborative.

## **Governing Structure**

The development of a clear governing structure has also been specified as important to the process. Collaborators need to understand to whom they are accountable and know that someone is there to settle disputes as they arise.<sup>108</sup> Established procedures for settling disagreements can help to avoid friction that is caused by the turf issues commonly found when people from different types of agencies work together.<sup>109</sup> An objective mediator can help a collaborative team work through disagreements, coordinate services, and involve families.<sup>110</sup>

## **Personal Choice**

Another factor in determining the success or failure of a collaborative enterprise is the degree of choice people have about participating in the collaboration. Those who choose to work as a part of a collaborative team tend to be more successful in reaching common goals than those who are forced to become members of such groups.<sup>111</sup>

## **Evaluation**

Collaborative ventures need to be evaluated on an ongoing basis.<sup>112</sup> When services are provided jointly by two or more agencies, they can be evaluated more effectively by collecting data across the system and keeping a centralized database.<sup>113</sup> For example, in some systems of care, the mental health agency is responsible for collecting data from each agency and maintaining a centralized database with a focus on system-wide indicators of success.<sup>114</sup> This data can be crucial for justifying the changes made in allocation of resources and for advocacy for continued funding of the system of care, as well as serving as a tool for internal management and decisions about programs at each agency.<sup>115</sup> Including a research component in the evaluation plan can provide a database for future

researchers, thus bringing in additional resources from universities.<sup>116</sup> Information provided by researchers and evaluations can then be used to make decisions about how to continue and improve the collaboration and to advocate for continued funding.

## **SUMMARY**

Research and experience with collaboration point to the importance of recognizing it as a process that requires time, dedication of resources, support from all levels and stakeholders, an established structure, commitment, and mechanisms to evaluate the success of its implementation. As with any relationship-building process, interagency collaboration depends upon the development of mutual trust and respect among all participants and a certain amount of agreement as to what is important and how problems should be approached. It requires the evolution of a common problem-solving procedure and language with mutually defined roles and responsibilities, but which allows room for autonomous decisions and personal choice. Because of this, collaboration needs the involvement of key people who have the authority, ability, and willingness to contribute significantly and effectively. At all levels, collaboration requires sharing power and turf by giving up individual claims to programs and outcomes, being flexible and willing to try things in different ways, accepting new job descriptions, trying to see things from different perspectives and looking for ways to understand what other people's work lives are like (their mandates, constraints, stresses, limitations, resources, time schedules, workloads).

Collaboration requires working cooperatively together rather than competitively, that involves ongoing communication, sharing resources, and dedication of time to processing, planning, consulting and evaluating. Choosing to collaborate in this way cannot be mandated, but it does require structural support in order to be functional and to bring in those who are less prone to collaborate before seeing its benefits. Collaborations that include the collection of data to demonstrate success in the form of improved services, outcomes and cost effectiveness provide a way to convince those who are more individualistic of its value. These data can also be used to advocate for continuation of funding and support from policy makers. The literature indicates that collaborative endeavors can bring about improved and more appropriate services for children and their families, but continued research is needed to describe this process and its outcomes.



# Chapter III

## The Foundations of Collaboration

---

### INTRODUCTION

The nine sites that participated in the *Promising Practices* study of interagency collaboration shared an interest in and dedication to developing collaborative processes in their service delivery systems. But each of these sites began the process of building collaboration in different places, at different times and with different concerns and needs. In short, the histories of the communities and service systems at each of these nine sites were different, and, as a result, the process of building collaboration was grounded in a different context at each site. This is important because the local context or the foundation on which collaboration was built influenced the strategies used by these sites to develop collaborative processes. This section of the monograph will discuss the experiences of the nine sites in the early beginnings of their collaborative work. It will focus on their starting points and the strengths and challenges they needed to consider as they began the process of building interagency collaboration.

The context surrounding early efforts to collaborate includes both strengths and challenges. These strengths and challenges can be considered the foundation on which collaboration was built. Strengths can be described as the positives, or the assets, that a system could draw from in their efforts to establish collaborative practice. Challenges can be considered the hurdles or obstacles that were faced in initiating collaboration. Although these sites varied in geographic size, population density and community need, several common themes in the foundations of collaboration emerged from the site interviews.

In describing the beginnings of collaborative practice, each of the sites identified both strengths and challenges relating to their early experiences in establishing collaboration. Among these early strengths, sites discussed the recognition of a need to change the way things worked, the relative advantages of having a mandate that in some way required collaboration, being able to build on the existing, but less comprehensive efforts of single agencies, the advantages of strong leadership, the consideration of size and resource base, the advantage of staff stability, and the contributions made by the Center for Mental Health Services grant funding.

Among the challenges to establishing collaborative practice, several limitations and fears were noted by participating sites. Individuals involved in this study often felt their early collaborative efforts were hindered by historic turf issues and finger pointing among potential collaborators, that a lack of understanding of and commitment to collaboration impeded progress toward collaboration, and that resentment and resistance to change slowed the process. The sites commented that both staff turnover and fears that collaboration would be too time demanding hindered their efforts. Additional challenges to collaboration were concerns about funding, varying levels of program development, and a sense that problems faced could not be solved. Last, but not least, sites mentioned that differing organizational cultures among child-serving agencies challenged the development of collaborative practice.

Both strengths and challenges in the foundations of collaboration are discussed in more detail below.

## **WORKING FROM STRENGTHS**

### **Collaborative Roots and the Mandate for Collaboration**

In many of the sites participating in this study, efforts to establish collaboration stretched back for many years and predated the Center for Mental Health Services grants for the Comprehensive Community Mental Health Services Center for Children and Their Families Program. Informants with the Ventura County Children's Mental Health Center in California noted that an interagency case meeting council was established in 1979 because of concern over "gray area" children and families that fell through the cracks and were not receiving needed services. Similarly, early efforts to assess community needs in Stark County, Ohio, brought a multi-agency group together in the early 1980s to document the need for children's mental health services. This interagency effort resulted in the formation of Stark County's Child and Adolescent Service Center. Informants in Rhode Island's Project REACH observed that prior to formal efforts to establish multi-agency collaboration, there were existing efforts in many agencies to work together and increase access for families. The *East Baltimore Mental Health Partnership* explained that early family involvement in service delivery contributed to establishing collaboration. Respondents with *New Opportunities in Oregon* commented that the established pattern of talking to one another and trying to hear everyone's voice aided collaboration, and a state-level Commission on Children and Families in the early 1990s focused attention on the needs of children and families.

But the early efforts toward collaborative work were not entirely voluntary. At many sites, the creation and implementation of mandates for interagency collaboration were identified as important instigators of change. One of the earliest examples of a mandate was found in Ventura County, California

where, in 1979, a County Supervisor required the establishment of an interagency case management council. The state of California passed state legislation in the 1980s requiring collaboration between mental health and special education and mandated the formation of county-level councils to oversee interagency collaboration and establish ongoing processes of outcome evaluation to assess the results of those efforts.

In other states as well, legislative efforts established frameworks and structures for collaboration. In Vermont, building upon a history of voluntary collaboration and following experience with a Child and

---

*Respondents in this study emphasized that a mandate for collaboration is simply not enough.*

---

Adolescent Service System Program grant, 1988 legislation required the formation of local interagency case management teams and mandated that annual care plans be developed for children with serious emotional disturbance and their families.

In Ohio, the state mandated the formation of an interagency structure called clusters in the early 1980s. And in Kansas, the legislature required the formation of interagency children's coalitions in each county, although it was noted that no funding was provided to support this change.

The issue of mandated collaboration came up early and often in our discussion of effective ways to build interagency collaboration. While mandates were described as helpful, and even crucial, in their ability to activate collaborative processes, increase public awareness and demand, and elicit at least minimal participation by child-serving agencies, respondents in this study emphasized that a mandate for collaboration is simply not enough. They stated that the important foundations upon which collaboration can be built cannot be required, cannot be ordered, and cannot be mandated. Respondents in this study believe that certain aspects of their local histories strengthened their early collaborative efforts and provided a crucial foundation on which to build true collaborative practice. These are discussed below.

---

*The important foundations upon which collaboration can be built cannot be required, cannot be ordered, and cannot be mandated.*

---

## The Desire to Change

The desire to change and a firm commitment to improving service to children and families is fertile ground for building collaboration. Recognizing the need to change was often noted as a strength and foundation upon which collaboration was built by the sites participating in this study. For example, informants with the *East Baltimore Mental Health Partnership* said that an early survey of child-serving agencies designed to determine the main reasons for existing gaps in services and lengthy waiting periods helped focus attention on the need to streamline services, reduce overlap, and decrease inefficiencies in service delivery. At this site, the

fact that people recognized a need to change contributed to the early beginnings of collaborative practice. In North Carolina's *PEN-PAL Project*, the earliest efforts to build collaboration were strongly aided by the fact that dedicated people genuinely wanted to be more effective in their work. Here, a starting point for the process of building collaboration was the fact that knowledgeable people, people who were interested in improving their skills through training, realized that working independently of one another was not serving children and families well. Their willingness to learn a new way of doing things contributed to establishing collaborative efforts in North Carolina's *PEN-PAL Project*.

---

*The desire to change and a firm commitment to improving service to children and families is fertile ground for building collaboration.*

---

Informants in Stark County, Ohio, described the frustration with the fragmentation of service delivery

---

*Awareness of the fragmentation of service helped establish a belief that collaboration among child-serving agencies would improve services to children and families.*

---

that was experienced by child-serving agencies in their community before collaborative processes were initiated. Their frustration with the fact that there was no coordination or leadership in situations where clients needed services from multiple agencies helped them to understand that children and families could be served better than they were being served. Awareness of the fragmentation of service helped establish a belief that collaboration

among child-serving agencies would improve services to children and families.

## **Strong Leadership**

Even when there is a broad-based willingness to collaborate, the need for stability, the ability to create an impetus for action and the ability to shoulder some of the burden of change were identified as important ingredients for initiating collaborative practice. For example, respondents in Ventura County, California felt that a strong leader acted as a "missionary for collaboration" by modeling collaborative behavior. Similarly, respondents involved with *KanFocus* felt that strong leaders were important because they took the need for collaboration seriously. The *East Baltimore Mental Health Partnership* commented that having strong leaders who were personally challenged by the process and tied to its success were important to their early efforts.

Even though the leadership role was described in terms of problem solving and pushing for progress, leaders were also described as providing a calming influence when tempers flared and tension was high. Respondents with *Access Vermont* believe their early collaborative efforts were strongly supported

by leaders who were “willing to take the flack, let people vent and reorganize through problem solving.” Respondents at this site added that it is important to have a leader who can serve as a “lightning rod” for people’s fears and concerns as collaborative processes get underway.

---

*The communities and participating agencies must be committed to choosing leaders who “aren’t hot-headed and have a sense of diplomacy.”*

---

Leaders were most often described in the plural rather than as a single individual. Many sites discussed the importance of having key leaders at different administrative and service delivery levels as well as across child-serving agencies. *Access Vermont* respondents offered the reminder that, particularly at the local level, the communities and participating agencies must be committed to choosing leaders who “aren’t hot-headed and have a sense of diplomacy.” Leaders like this are valuable because they can help problem solve, try new things, and they are able to see progress and publicize positive results.

## Size as a Factor

The size of the sites, both in geography and population density, was identified by some of the rural and small county sites as a strength in their early progress in building collaboration. According to respondents in Vermont, Ohio, and California, the important advantage of building collaboration within a relatively small service delivery system was reduced complexity. This was advantageous in Vermont, where the State Division of Mental Health was described as having relatively little hierarchy, because it made change easier to introduce. Reduced bureaucracy was also noted as a strength in San Mateo County, California, where respondents said that people in child-serving agencies were able to think of themselves as equals, even at different levels of agency bureaucracy. Stark County, Ohio was described by respondents as a community that is small enough to allow easy familiarity among child service workers, across agencies, and at different administrative levels within an agency. In Ventura County, California, respondents described the size of their county as an advantage because it was “not too big, but big enough to have enough players.”

## UNDERSTANDING THE CHALLENGES OF COLLABORATION

### Varying Commitment to Collaboration

In the early stages of building collaboration, child-serving agencies, from administrative to direct-service levels, have little experience with what collaboration means, how it will change the nature of their work, or what resources it will require. Respondents at many sites commented that this lack of experience

translates to an uneven commitment to collaboration on the part of participating agencies – even those that may have pledged their support in writing grant proposals or forging interagency agreements.

Several sites noted that, particularly in the beginning, not everyone is interested in or good at collaborating. In *East Baltimore*, participants responsible for establishing the *East Baltimore Mental Health Partnership* realized early on that commitment to the inter-group process varied among agencies and among individuals within those agencies. In Kansas, where *KanFocus* incorporated service delivery to children and families in 13 counties, respondents found that the counties began the process of building collaboration with different levels of cooperation. An early recognition of the challenge presented by varying levels of commitment to the collaboration process is useful because it highlights the need to develop strategies that will clarify the mission and goals of collaboration as well as demonstrate the advantages of collaboration to less enthusiastic participants.

Participants in this study indicated that the varying commitment to collaborative processes are often rooted in fear and animosity — fear of the unknown and animosity resulting from a historically poor communication and competitive relationships. These issues are discussed in more detail below.

## **Blame, Resentment and Distrust**

All of the sites participating in this study identified “turf issues” and blame as an initial challenge to their collaborative efforts. Turf issues were described by participants in this study as connected to issues of power and control. Examples of turf issues included the tendency of agencies to define service delivery in terms of “what’s mine” and “what’s yours,” rather than focusing on how to work together with “what’s ours.” Participants in this study agreed that the blame and finger pointing resulting from this attitude are powerful deterrents to building collaboration. The sites participating in this study also agreed that these challenges are particularly difficult to negotiate when collaboration is in its early stages and its benefits have not yet been demonstrated.

In states where local participation in collaborative efforts was legislated or mandated by state government, resentment slowed progress toward collaboration. For example, both state-level and local-level respondents in North Carolina expressed concern that because *PEN-PAL* was initiated at the state level, it was more difficult to generate community involvement in the process.

Similarly, resentment of the systems reform efforts underway in Baltimore prior to the Center for Mental Health Services grant had created suspicion and resentment for the *East Baltimore Mental Health Partnership*,

---

*Challenges are particularly difficult to negotiate when collaboration is in its early stages and its benefits have not yet been demonstrated.*

---

according to respondents from mental health and other agencies. This initial distrust had to be later overcome. In Oregon, study participants commented that it required three to four years to heal resentment and lack of trust by residential providers resulting from outcome goals that included a reduction in residential service.

Family members interviewed for this study often described feeling estranged from the service planning and delivery process during their early experiences with child-serving agencies and identified this as the reason for an initial distrust of collaboration. Families and service providers alike reported that a lack of clarity in the role of family members, both in how families would participate in formal collaborative planning meetings and in how they could advocate for their own children, created resentment and distrust between families and service providers. As a result, families have felt peripheral to the service delivery process. Both service providers and families feel that a lack of trust between families and service providers is a challenge to building collaborative practice.

Respondents in both North Carolina and San Mateo County, California noted that adherence to a medical model of service delivery can create challenges in defining the role of families in service delivery. The medical model, that relies heavily on the expertise of professionals in determining the appropriate treatments and service placements, does not provide a clear role for family members in service planning and delivery at a system level or in determining appropriate services for individual children and adolescents.

## **Inflexibility and Resistance to Change**

Establishing collaborative practice means forging changes in the way services are delivered, in who is involved in decision making, and even in what kinds of services are available. One of the initial impediments faced in the process of building collaboration was characterized by respondents as bureaucratic inflexibility. Study participants in both North Carolina and *East Baltimore* discussed the difficulty presented by bureaucratic rules, which stood in the way of changes brought about by collaboration. This was particularly evident when local-level, community generated change was restricted by state regulations.

Participants in Ventura County, California, noted that a pattern of maintaining the status quo results in resistance to change. People become comfortable with the way things are. Change, however, requires new adaptations and risk taking. Similarly, Stark County, Ohio observed individuals and agencies at their site holding onto things because “it’s the way they have always been done.” This resistance to change slowed progress toward collaboration. Respondents in Vermont found that people had to trust in their

ability to make a difference and to find a positive solution to the challenges they faced before they were willing to attempt change. This resistance to change, based on fears among service providers that they lack the ability to find solutions, was also noted as a challenge to building collaboration.

## Time Requirements

Particularly among direct service or line staff, the move toward collaboration was accompanied by fear that there would not be enough time to do more than they were already doing. Rhode Island respondents noted that interagency partners feared that they would be asked to do more when they were

already overloaded. With the additional pressure to increase

---

*Experienced collaborators found interagency collaboration reduced the work load and work pressures rather than added to it.*

---

productivity coming from managed care models of service

delivery, time is a crucial element. Respondents from the *East*

*Baltimore Mental Health Partnership* acknowledged the fatigue

and stress associated with coordinating schedules and trying to

get key stakeholders together in a timely manner. Sites also noted

that the time devoted to collaboration was often considered

volunteer time because the meetings were not billable hours.

However, experienced collaborators found interagency collaboration reduced the work load and work pressures rather than added to it. For example, line staff in the North Carolina *PEN-PAL Project* found that the pressure they had felt in making their toughest placement decisions was reduced when interagency teams took greater responsibility. This was such a positive outcome of collaboration that initial concerns for the extra time required by collaboration were replaced by an attitude that it was worth the effort.

# Chapter IV

## Strategies for Implementing Collaborative Processes

---

### INTRODUCTION

During the interviews for this project, agency staff and family members talked about strategies they felt were successful in establishing collaborative practice in their communities. The contexts in which these system of care initiatives took place varied considerably from one to another. For example, some of the collaborative initiatives, such as Stark County, Ohio and Ventura and San Mateo Counties in California, were county-based efforts, while sites like Vermont and Rhode Island involved statewide reform efforts. North Carolina and Kansas targeted multiple counties in their efforts, and Baltimore focused on a specific neighborhood in a large urban city. Although the sites were quite different from one another, there were many similarities in the strategies used by these sites to build collaborative practice.

In this section, the strategies that were identified as the most promising tools for building collaborative practice are discussed. These strategies could be grouped into three broad categories: 1) strategies that focus on structural elements such as governance, funding, and interagency agreements, 2) strategies focused on relationship building among collaborative partners, and 3) strategies for involving families and the community in the development of collaborative processes.

### STRUCTURAL ELEMENTS OF COLLABORATION

#### Establishing a Governance Structure

According to respondents in Vermont, “structure is essential to success” when establishing a collaborative environment for human service delivery. The real lesson in establishing collaborative structure, however, is the importance of involving multiple administrative and service delivery levels of the child-serving organizations in the collaborative structure. The experience of participants in this study is that successful collaboration requires a commitment from administrators, supervisors and direct service staff throughout an organization, and that multi-level collaboration creates a better service delivery system. This multi-level approach is important within each individual service agency as a strategy for creating

---

*“Structure is essential  
to success.”*

---

agency-wide commitment to collaborative practice. Collaboration must also occur across agencies to impact policy and direct service levels of the system of care. A multi-level approach, both within and across child-serving agencies, is important in establishing interagency collaboration.

With regard to cross-agency collaborative structures, respondents with *KanFocus* cautioned against involving only administrators in formal collaborative groups, even though they carry significant authority in their agencies. Although *KanFocus* recommended bringing “policy makers and people with purse strings” to the table, this site found that it is important to balance the involvement of agency administrators with the involvement of direct service workers, who are able to make good line-level decisions about how to integrate collaborative practice into their day-to-day work.

---

*Successful collaboration requires a commitment from administrators, supervisors and direct service staff throughout an organization.*

---

Similarly, collaborative participants in *East Baltimore* recommended creating structures that facilitate collaboration at both top and mid-levels of administration. *East Baltimore* found that the involvement of agency heads was important for establishing collaboration as a priority focus for the

---

*A multi-level approach, both within and across child-serving agencies, is important in establishing interagency collaboration.*

---

participating organizations. Mid-level administrators, on the other hand, were included in a multi-agency case coordination committee for the purpose of addressing how the collaborative process works on a day-to-day basis and in instituting cross-agency case reviews. In addition to collaborative groups that bring together

coequals across child-serving agencies, *East Baltimore* created liaisons for each child-serving agency to serve in both a cross-level and cross-agency problem-solving capacity. These liaisons report directly to the agency heads and have the authority to cross departmental boundaries. The interagency liaison role is one of problem solving and facilitating collaborative practice that allows liaisons to attend to issues outside of their own agency. The liaisons have beepers and can be contacted at any time, by any agency.

Formal interagency agreements provide another type of structure on which to build collaboration. In Ventura and San Mateo Counties in California, interagency meetings are supported by written interagency agreements among child-serving partners in special education, juvenile justice and child welfare. These agreements, called memoranda of understanding, formalize the relationships among child-serving agencies. Respondents at both California sites stressed that these interagency agreements have provided a formal platform on which to base collaborative practice, although some concern was expressed for the fact that family members have no formal role in creating these documents.

The California and *East Baltimore* sites represent county or locally-based collaboration. At other sites, the structure of collaboration at the local level was defined by state level administrators. For example, in Vermont, state government defined the population of children to be served and made new funding available for local level programs as an incentive to create new services and work collaboratively. Receiving these funds required that local-level collaborative partners be identified and sought out. The state established community-level planning groups and governance structures, and local efforts were supported by a state outreach team through training, technical assistance, and evaluation feedback.

The *PEN-PAL Project* in North Carolina represents another state-initiated effort to create a community-based collaboration. Monthly meetings of the local-level Project Management Committees (PMC), that include agency representatives as well as family advocacy representatives, focus on improving service delivery strategies to meet family needs. Although the PMC structure was created at the state level, their size and role have changed as they have been implemented locally. Originally, a single PMC was created for the three counties participating in the *PEN-PAL Project*. Since then, the number of PMC participants has changed and the original PMC has become two separate organizations, in an effort to better represent local concerns.

After more than a decade of experience building collaboration in California, respondents from Ventura and San Mateo Counties suggest that while it is important to have a formal structure, it is also necessary to remain flexible and open to change. This flexibility allows the formal structure to adapt to changing circumstances and makes it possible for collaborators to stay aware of which decisions can be made informally and which must be more structured.

---

*While it is important  
to have a formal  
structure, it is also  
necessary to remain  
flexible and open to  
change.*

---

Stark County has found it very effective to fund a collaborative-specific staff that provides the infrastructure for all the child-serving systems in the county and is directed by a board of trustees made up of top executives from collaborative partner agencies. The Stark County Family Council coordinates and integrates services through blended funding from the partner agencies, with additional funding from federal, state and community grants that were brought in by the efforts of the Family Council staff. Respondents believe that this strategy has prevented any single agency from being over-burdened by the collaborative process and has helped avoid turf issues by placing the collaboration on neutral ground.

## Group Decision Making

Effective collaboration requires a shift to group decision making rather than a single agency retaining authority and control. Stark County respondents commented that collaborative decision making takes longer and requires more patience, but report that an absolute commitment to this approach has helped keep interagency partners at the table even when disagreements about what services are appropriate for a particular child and family have been heated and difficult.

The structural strategies that create interagency collaborative bodies serve the important purpose of helping to make a shift in decision making about service delivery. Formal collaborative structures serve the purpose of providing a forum for group decision making and foster a team orientation. Respondents in North Carolina emphasized that group decision making requires practice and that collaborative partners must be repeatedly encouraged to use one another as resources by asking one another questions and getting opinions from other members of the group. Similarly, *East Baltimore* respondents emphasized the importance of getting to know collaborative partners at a personal level, to reduce the turf issues that are a common challenge to building collaborative service delivery.

---

*Shared decision making across child-serving agencies is a necessary component of collaboration because it helps equalize the power bases.*

---

Shared decision making across child-serving agencies is a necessary component of collaboration because it helps equalize the power bases. Although necessary, interagency decision making is not sufficient for building strong collaboration. Rhode Island found that to be truly collaborative, the groups responsible for decision making had to include service delivery professional and paraprofessional staff, as well as family members. In that way, shared decision making is considered nested throughout an organization rather than existing only at the policy making levels of participating agencies.

Building trust is a necessary component in developing the capacity for shared decision making. Respondents from North Carolina's *PEN-PAL Project* noted that it takes time for people to get to know one another so they can let their defenses down and begin to build collaborative relationships. In Stark County's experience, the power shift toward group decision making included training people to make service delivery decisions independently in the field as a strategy to reduce bureaucracy and increase the responsiveness of service providers to children and families.

Ventura County in California tied shared decision making to shared fiscal responsibility among collaborative members. This approach was possible in California because system of care reform efforts

provided a financial incentive for collaboration at the local level. The goal of reinvesting funds diverted from expensive restrictive services into less restrictive community-based services motivated interagency efforts to focus on joint problem solving. The result of these efforts was the generation of new service strategies through performance contracts with county government. The responsibility for the success or failure of these new service strategies was shared by all members of the collaborative. This process of developing new services as a collaborative team has helped institutionalize collaboration among interagency partners by demonstrating how working together both improves services and helps agencies reach their own goals and objectives. The Ventura County respondents emphasized, however, that building shared responsibility takes discussion and requires formal procedures and parameters as a guide.

## **Funding Collaboration**

Funding collaboration was a highly-charged issue at many of the sites participating in this study. As one respondent commented, “Collaboration isn’t free.” Respondents across the participating sites indicated that talk of funding changes and restructured financing surfaced many fears among potential collaborators, the most significant of which was a fear that collaboration would result in an actual loss of resources that would make their jobs more difficult. At one site, the term “pooled funding” had such negative connotations as a result of previous reform efforts that participants in the Comprehensive Community Mental Health Services for Children and Their Families Program had to use other terms to describe shared resources. Participants at *KanFocus* commented that although they did not want collaboration to be built on money, they found that “some people wouldn’t come to the table without it.”

---

*“Collaboration  
isn’t free.”*

---

The availability of new funding for collaboration is sometimes viewed with suspicion. Some sites expressed concern that the availability of new funding can attract individuals and agencies who are more interested in new sources of money than improved ways to serve children and families. In this situation, there is fear that the resulting collaboration will be compliance-oriented rather than solution-oriented and in the spirit of “true collaboration.” Fears aside, however, it was the availability of a pool of funds for flexible use that provided the foundation and motivating force for real innovation in collaborative service delivery at many sites.

Two types of strategies have been used to pool funds. One strategy is to pool money contributed by individual collaborating agencies. This is threatening to potential collaborators because they fear that they will lose money or lose control over how money is spent, without any guarantee that it will help them better serve the children and families they are responsible for. Another strategy is to create a pool of new dollars

available as flexible funds. This strategy of seeking new funds was used at many of the sites participating in this study, with varying sources for the new pool of money, such as private foundation grants, and state and federal grants.

The ability to pool funds for flexible uses was described as “a watershed event” in the process of

---

*It was the availability of a pool of funds for flexible use that provided the foundation and motivating force for real innovation in collaborative service delivery at many sites.*

---

building collaboration in Stark County, where these funds were used to support family involvement through the Stark County Family Council and to provide funding for their interagency councils. Similarly, the ability to put new money on the table for collaboration was described as a crucial collaborative strategy by participants in Vermont who said, “It’s less of a struggle to plan together when you have new dollars, not just

re-arranging what you have. Local people know that what they have is inadequate and suspect a shell game if you don’t have new money.”

The sites all commented that the federal grant for the Comprehensive Community Mental Health Services for Children and Their Families Program provided crucial funding for building collaborative practice. At every site, these dollars were used to create new and innovative service delivery strategies that were developed through collaborative interagency planning.

## **Personnel Decisions**

A useful strategy for fostering collaboration at the sites participating in this study was to hire individuals who understood and valued collaboration. Respondents in Ventura County in California strongly recommended hiring new staff based on how well they worked collaboratively and emphasized the necessity of including questions about collaboration in the interview process. For example, Ventura County mental health staff recommend involving interagency partners in the interviewing and selection process. In addition to integrating collaboration in decisions to hire new staff, the ability to collaborate was included as a criterion for both reward and promotion.

The importance of using personnel decisions as a strategy for building collaboration is also illustrated in three other sites. In the *PEN-PAL Project* in North Carolina, participants have found that it is important to actively seek new staff “who are creative and interested in new ways of doing things.” *New Opportunities in Oregon* used staff placement as a strategy to impact collaboration and create a “trickle through the agency

effect” by funding family support workers as case managers and placing them in 14 child-serving agencies in their community. The goal of this strategy has been to make mental health a model of collaboration by demonstrating how mental health can contribute positively to other children’s services through these case management positions. The *East Baltimore Mental Health Partnership* has been able to model family involvement by including family members in staff hiring decisions.

## Staff Training

Training has proved to be an important strategy for reinforcing the structural changes such as pooled funding and the creation of formal collaborative committees and boards. North Carolina has instituted in-service training across agencies to help interagency partners understand each other’s paperwork requirements, share ideas and resources, learn about different organizational cultures, and create unity. North Carolina has also created Agency/Academic Partnerships for the purpose of training and moving toward collaborative practice. This emphasis on training has created both pre-service and in-service trainings and technical assistance on the subject of building systems of care. Respondents in North Carolina believe that the focus on training has been critical to building collaborative practice.

---

*Training has proved to be an important strategy for reinforcing the structural changes such as pooled funding and the creation of formal collaborative committees and boards.*

---

Vermont has used training to help overcome the fear that collaborative practice could not be successfully implemented at the local level by training staff in strategies for building collaboration. This training of staff aided their ability to interact with interagency partners around issues of collaboration. These training sessions were reinforced by the availability of flexible funds to create new collaborative service delivery strategies at the local level, allowing participants to operationalize what was learned.

Other sites have used training to educate interagency partners about the missions, roles, mandates, limits, and laws affecting collaborating agencies. Several sites have used retreats as a strategy for training and creating unity. For example, the *East Baltimore Mental Health Partnership* has organized retreats during which cases are presented by a panel including representatives from mental health, child welfare, juvenile justice and education as well as family members. The panel discusses the process of collaboration as it has related to these cases and talks about how issues and barriers were addressed. *East Baltimore* stressed that training people to think collaboratively has helped participants redefine their role from being a single expert to being a team

---

*Several sites have used retreats as a strategy for training and creating unity.*

---

member. North Carolina created a Best Practices Institute retreat during which successful practices from multi-agency cases were presented. This recognition of successful practice reinforced the further development of collaborative processes.

## **Neutral Ground**

Some participants in this study have found that the physical location of where collaborative meetings are held can make a difference. Rhode Island found that physically moving Community Mental Health into the community spoke to issues of access and provided a statement of shifting power to the community. Stark County strongly recommended moving the location of collaborative meetings out of a single agency and onto neutral ground. In their experience, this shift provided greater visibility for collaborative activities and offered a more open atmosphere. Respondents in *East Baltimore* reinforced the importance of having collaborative meetings in easily accessed community settings so that everyone can feel a part of the process.

## **RELATIONSHIP BUILDING STRATEGIES**

### **Start Small and Strategically**

Start small. That advice on how to begin building collaborative processes into a child-serving system was offered by each of the nine sites participating in this study. Respondents believed that a

---

*Respondents believed that a willingness to start small was one of the keys to success.*

---

willingness to start small was one of the keys to success. In part, this is a recognition that, especially in the beginning, not everyone is willing to participate in collaboration. Because of varying levels of interest in collaboration, respondents from Stark County believe that early collaborators must be willing to start small and add participants strategically as interest in the process grows. San Mateo County

respondents found that starting small allowed them some early success because they included people who were interested in collaboration and who would follow through on the commitments they made to the collaborative process.

As an organizing principle, starting small does not mean excluding individuals and agencies that are willing to participate, but it suggests that there is wisdom in identifying the willing collaborators and beginning the process there. Respondents in Rhode Island's Project REACH commented that the more experience you have in building collaboration, the more strategic you can be in involving new collaborative partners.

Starting small is a way to build experience in the collaborative process. Similarly, a respondent in North Carolina suggested, “Don’t try to change everything at once.” They added that collaboration is a process of development, so starting small “allows you to grow a strong and effective collaboration.”

Ventura County respondents carried the idea of starting small into program development and implementation. Programs and services resulting from collaborative efforts are often substantially different from the categorical services offered by single agencies. Collaborative efforts involve staff from multiple agencies in shared decision making and often attempt to streamline decision processes by creating different lines of authority within and across child-serving organizations. Ventura County respondents suggested a strategy of building collaboration slowly by initiating one program at time. In their experience, the creation of even one new interagency service provides a valuable model of successful collaboration at the program level. Their experience suggests that this approach is useful in shifting thinking away from the traditional focus on single-agency programs and fosters the idea that this is “our money” serving “our” children and families, rather than “my money” serving “my” children, by providing a ready example of the results of successful collaboration.

---

***“Don’t try to change everything at once.”***

---

Participants in this study commented that experiencing success in serving children and families is what makes collaboration worth the effort. Starting small also provides an opportunity to build on strengths and direct the attention of the collaborative toward creating early successes. As a respondent at *KanFocus* commented, “People like to see change, movement, success.” *KanFocus* recommended using early successes to build more success. Vermont respondents commented that because change is so difficult, it is easy to be overwhelmed by the challenges of collaboration. Starting small allows time to recognize the positives and build from there.

---

***Starting small allows time to recognize the positives and build from there.***

---

## Building on Strengths

Sites participating in this study also pointed out the benefits in knowing where to begin. The sites agreed that it is important to start with the right people by identifying individuals who have a reputation for working well with their colleagues. Respondents in Ventura County chose people who were flexible and open-minded to spearhead their collaborative efforts. Rhode Island recommended identifying and cultivating a core group and building from there. Similarly, the *East Baltimore Mental Health Partnership* recommended finding the “natural points of collaboration” and building on that. These natural points can be found among agencies and individuals who express an initial interest and commitment to collaborative

practice. *East Baltimore* used a strategy they referred to as “each one reach one” to recruit new participants and build a critical mass of collaborators. This strategy involved each experienced collaborative partner taking responsibility for bringing a prospective collaborative member into the process.

Respondents in Vermont pointed out that it is valuable to build on past experience with collaboration. Many locally based community organizations in Vermont already had experience with collaboration. When the state-level education and human service agencies created regional Community Partnerships throughout the state for the purpose of fostering collaboration among agencies, many of the local community organizations were able to actively support these partnerships and offer the benefit of their experience. Respondents in Oregon also mentioned that community-based organizations contributed positively to their collaborative efforts. *East Baltimore's* strategy for building on strengths includes reaching beyond agency participants and into the community in order to build collaboration. Participants in *East Baltimore* recommended “getting out into the community” and talking about the importance of working together collaboratively so that collaboration becomes “an everybody issue” rather than strictly the burden of the four core child-serving agencies (mental health, child welfare, education, and juvenile justice).

## **Recognizing Limitations**

Collaborative practice involves forging new relationships and breaking new ground. Interagency partners often enter into the process of building collaboration with long-held (and sometimes negative) assumptions about the other participating individuals and organizations. Participants in this study recognized that a lack of information about and understanding of the resources, intentions and bureaucratic regulations of the interagency partners is a threat to building collaboration. Because collaboration “is not a one-way relationship,” it is important to build trust by recognizing both the strengths and limitations of participating agencies.

North Carolina's *PEN-PAL Project* found it was useful to conduct an “agency asset assessment” early in the process of building collaborative practice. This assessment was developed to help agencies

---

*Because collaboration “is not a one-way relationship,” it is important to build trust by recognizing both the strengths and limitations of participating agencies.*

---

understand the mission and structure of their organization as well as to appreciate “a day in the life” of collaborative partners. This strategy proved very useful in helping agencies recognize the limitations as well as the strengths of their interagency collaborative partners. The results of the agency asset assessment were reported at a retreat

for interagency partners and provided a positive opportunity to recognize the “daily heroic efforts buried in people's every day work.”

Efforts such as the agency asset assessment also serve the purpose of educating interagency partners as to what an agency is and is not able to contribute to the collaboration because of the parameters set by its mission, its goals, or legislated restrictions on the use of its resources. In Stark County, a respondent from the agency serving children with developmental disabilities recounted early frustrations with what was perceived as the agency's seeming unwillingness to accept referrals from collaborative child-serving agencies. Although interagency partners initially distrusted the practices of this agency, their perceptions slowly shifted to trust and respect as they began to understand how legislation placed limitations on which children could be accepted into long-term services for developmental disabilities.

A strategy used by Stark County to foster mutual understanding among agencies was the Walk in My Shoes program. This program placed middle managers in different child-serving agencies during a six-month period, rotating them into a new agency every two months. The participants met weekly to discuss their inter-system findings. This sensitized participants to the focus and priorities of each agency, different vocabularies, funding strategies, program orientations and the different skills and limitations of the manpower in each agency. One respondent described his experience as "understanding their issues... it was their work climate, with their reality, and I just needed to understand what it was... you don't want to assume you understand somebody else's life or their system..."

## **Nurturing Collaboration**

Even among willing collaborators, it is necessary to overcome initial hostility and begin to build trust. Past relationships among interagency partners have sometimes been antagonistic. Nurturing collaboration involves developing strategies to remind collaborative partners of the good reasons for collaboration and make it worthwhile. Nurturing helps shift thinking from self-centered or agency-centered thinking to a realization that collaborative partners are building collaboration for the greater good.

---

***E**ven among willing collaborators, it is necessary to overcome initial hostility and begin to build trust.*

---

One important nurturing strategy is making collaboration valuable to individual participants and their agencies. Respondents in Stark County noted that participants needed to see the value to them in collaborating – whether in funding assistance, increased availability of services, or moral support during difficult situations. Demonstrating the value of collaboration in tangible ways helped overcome fears that collaboration would cause more work without providing any benefit. Respondents in North Carolina suggested creating “win-win” situations so that agencies learned that their participation in collaborative processes would support their own efforts instead of working against them. One “win-win” strategy that

can be offered through mental health agencies is to create mental health services that meet the needs of other agencies. For example, at several sites participating in this study, mental health agencies used the Comprehensive Community Mental Health Services for Children and Their Families Program grant dollars

---

*Demonstrating the value of collaboration in tangible ways helped overcome fears that collaboration would cause more work without providing any benefit.*

---

to fund mental health positions in juvenile justice, education and child welfare agencies. This strategy fostered reciprocity by effectively modeling the idea that collaboration is for the greater good and demonstrating that if you give to the collaborative today, your efforts will be repaid to you later.

Rhode Island respondents offered a reminder that the processes of building trust and making collaborative partners feel safe participating in the collaboration takes time. It is important to develop strategies that reinforce collaboration again, and again, and again. Respondents in *East Baltimore* noted that it was necessary to build an understanding of what the collaborative process is by repeatedly contacting potential collaborators to explain the purpose of collaboration and how it works. Because collaborative partners often do not know one another, several sites participating in this study recommended creating opportunities to bring people together in an environment that is less formal than a meeting. This included getting together with interagency partners for breakfast or lunch. A respondent in Ventura County said, "We eat and talk together; talking is the key to developing relationships, respectful, trustful relationships. You get some perceptions of their concerns and problems. It's critical."

Sometimes a lighthearted approach can nudge interagency partners who are simply compliant in attending collaborative meetings to become true participants in the process. In the early days of collaboration in Stark County, dinosaur toys were placed on the conference table during interagency meetings. Anyone caught hanging onto old ideas and defending fragmented services was given a dinosaur toy as a good-natured reminder that the goal was to move toward new ways of working together. Alternately, San Mateo County respondents agreed that it is important to confront collaborative members who are thinking only of their own agency in a straightforward manner by pointing out their behavior.

Laughingly, but not without a measure of seriousness, the strategies of peer pressure and guilt were both mentioned as explicit and successful strategies for building collaboration. Participants in *KanFocus* began by placing two or three key people on their collaborative board and then used peer pressure to "encourage" the attendance and participation of less enthusiastic collaborators. Several sites offered the reminder that it is more difficult to say "no" to a group of peers than to a single person or agency. In this light, sites purposefully created situations in which a reluctant collaborator was made answerable to a group rather than to an individual. For example, conference calls or video conferences were

---

*It is more difficult to say "no" to a group of peers than to a single person or agency.*

---

used in several sites to gather potential collaborators together when face-to-face meetings were not possible. One site went so far as to purchase speaker phones for collaborating agencies so that conference calls were more convenient and feasible. This strategy effectively reinforced the strategy of group decision making.

Some nurturing strategies are more subtle.

For example, in Stark County a sign that simply reads, “COLLABORATION” hangs quietly over the door of the room where interagency partners gather for collaborative meetings, a silent reminder of the real work of those who meet there. Inside the room, the mission and goals of the collaboration are posted prominently on the walls, and colorful posters remind collaborators that children and families are at the heart of their work.

---

*Sites purposefully created situations in which a reluctant collaborator was made answerable to a group rather than to an individual.*

---

## Encourage Innovation and Risk

Collaboration requires participants to think bigger and to act beyond their own agency by identifying new ideas and new solutions that are not bound by an individual agency. Collaboration requires understanding that an individual service provider or agency's actions do not happen in a vacuum and must be understood more holistically in the context of a child and family's life within their community and with respect to other child-serving agencies. Moving beyond an agency-centered focus on service delivery requires both innovation and risk taking by collaborative partners because it means looking for new ways to meet the needs of children and families. As participants in Ventura County commented, “You need to take chances in order to do things differently.”

Participants in this study, however, recommended against adopting a strategy of high risk in favor of a strategy of taking calculated or strategic risks, that could demonstrate successful results. This was particularly important early in the collaborative process when failed attempts at collaborative service delivery

---

*“You need to take chances in order to do things differently.”*

---

might have ended efforts to build collaboration. The important result of risk taking is the creation of innovative and responsive programs. For example, *East Baltimore* established collaboration between therapists and teachers through an innovative school-based mental health program that includes school-based family, group and individual therapy, consultation to staff for behavior management strategies, and pro-social skills training for children with early signs of aggressive or disruptive behavior, as well as therapeutic after-school and summer school programs. Planning for this program was a collaborative effort involving school

administration, teachers and therapists. The involvement of therapists in a community-based school setting helped remove the stigma associated with mental health services and increase access to services for children and families.

Although risk taking was identified as a strategy for creating new service delivery options and building collaboration in many of the sites participating in this study, the concept of risk-sharing described by participants in Stark County offers a new twist on innovation that supports the building of collaborative practice. The concept behind risk-sharing is that no one agency should have to bear the singular risk and responsibility of helping children and families. Interagency collaborative participants in Stark County have adopted a philosophy that the community as a whole is responsible to its citizens and that child-serving agencies share that responsibility through collaborative service delivery.

## **Communication and Regular Meetings**

One of the fears experienced by people who participated in this study early in their collaborative processes was that collaboration would take too much time because of the number of meetings. Although the experienced collaborators in this study concurred that collaboration does take time, one of the most frequently mentioned strategies for building collaboration was to hold regular meetings with interagency partners. Regular meetings helped achieve a number of goals. In Ventura County, meetings were used to create enthusiasm among participants and to keep interest strong. In the *PEN-PAL Project*, regular meetings, both formal and informal, helped create a tool of communication across agencies and among staff within agencies. In Oregon, regular meetings were used to keep interagency partners informed and participating, as well as to help them understand differences in the ways individual agencies operated. Rhode Island used meetings as an opportunity for their Local Coordinating Councils to learn from one another while developing systems that met the needs of their specific communities. *East Baltimore* found that regular meetings gave participants valuable opportunities to address their issues and fears directly. As an *East Baltimore* participant pointed out, it's important not to act like fears and turf issues are not there; they must be put on the table. Regular meetings allow participants to deal with conflicts before they escalate.

---

***Regular meetings gave participants valuable opportunities to address their issues and fears directly.***

---

Regular meetings were the most often mentioned tool of communication identified in this study, but experienced collaborators also incorporated other methods of communication into their strategies for building collaboration. Both North Carolina and Stark County have created short video presentations that

describe their collaborative initiative and why it is both innovative and important. These sites report that their videos have given them the opportunity to communicate their collaborative message to a larger audience and have allowed more consistency in communicating the mission and goals of their collaborations.

Other high-tech communication strategies have included using video conferencing through a network of local community colleges as a way to reduce the challenge of geographic distances to collaborative efforts. Videotaped training sessions with valuable outside consultants have made it possible to extend the utility of a particular consultation. At sites where staff turnover across agencies has been a challenge to collaboration, a library of training videos has been developed as a strategy to educate new staff in the role of collaboration in service delivery. Some sites have prepared short announcements for their public access cable stations and another has developed a cable television program about their initiative.

Putting collaboration procedures in writing is a communication strategy recommended by both Ventura County and San Mateo County, where formal memoranda of understanding among collaborative agencies are updated as needed. These agreements provide a structure that holds agencies accountable to one another by defining the role of agencies in relation to one another. In addition, a manual is made

---

*Putting collaboration procedures in writing is a communication strategy recommended by both Ventura County and San Mateo County.*

---

available to participating agencies that details the basic requirements for interagency agreements.

Meetings, videos, conference calls and formal agreements aside, the sites participating in this study agree that nothing substitutes for simply talking about collaboration with collaborators and potential collaborators. Participants in Vermont stated it most simply when they said that they encouraged a strategy of “getting out there and having conversations,” that included discussions of where participants would like to be in the future and how they thought they could get there.

## Patience and Persistence

Collaboration is not built overnight, and all of the sites involved in this study spoke to the long-term commitment required to develop collaborative processes. The collective wisdom of these participants was that it is important to recognize that collaboration takes time. North Carolina respondents pointed out that it is necessary to recognize the long-term nature of change. Although the Comprehensive Community Mental Health Services for Children and Their Families Program is on a five-year time line, participants in the

---

*It is important to recognize that collaboration takes time.*

---

process of building collaboration estimate a much longer process of development. Respondents in Ventura County have worked at building collaboration for more than 10 years. A site only five years into the process estimates the change toward true collaborative practice will probably require 15 to 20 years to establish, even with consistent and persistent effort. A respondent in San Mateo County commented, “you understand what collaboration is from experiencing it.” A respondent in *East Baltimore* described the stages of collaboration as, “get people to think differently, then they start talking differently, then the actions come ... It’s a process, not an event.” The long and the short of it is that building collaborative experience across agencies takes time.

---

*Due to the long-term nature of collaborative change, it is important to establish both short- and long-term goals.*

---

Participants in this study advise that, due to the long-term nature of collaborative change, it is important to establish both short- and long-term goals. Achieving early success builds more success, but setting long-term goals helps to maintain momentum for pursuing the stated vision and mission of the collaborative initiative. Participants in Stark County call the focus on long-term goals “setting far-markers” and expressed the belief that their long-term goals have guided their decade-long efforts toward building collaboration.

## **FAMILY AND COMMUNITY INVOLVEMENT**

In addition to structural and relationship-building strategies for implementing collaborative practice, participants in this study identified the involvement of families and the community in collaborations as a critical strategy for developing and sustaining collaborative practice.

### **Involving Family Members**

Both family members and service providers participating in this study made the point that family involvement means more than being respectful of families or having a place for family members on a collaborative community council. Family involvement in collaborative processes means really involving families in decisions that affect the planning and delivery of services in the community, as well as in decisions that shape services for their own children. Family involvement in collaborative processes means extending the strategy of shared decision making that is so crucial to the process of professional collaboration to include parents and other caregivers.

Participants in this study expressed the strong belief that family involvement in service planning and delivery is *THE* component that assures effective interagency collaboration because, it allows an honest assessment of the needs of the child and family. But family involvement, itself, was often described as hard

to achieve. The sites participating in this study have experienced varying success in integrating family members into the collaborative process. This may be, in part, because the most common focal point for

---

*Family involvement means more than being respectful of families or having a place for family members on a collaborative community council.*

---

initiating collaborative processes has been the development of formal ties and structures among child-serving agencies.

Even when families were included in the formation of interagency collaborative structures such as community service boards or local coordinating committees, the role for families has been difficult to define. As a result, the

involvement of families in collaborative processes was often described by both family members and service providers as elusive and difficult to achieve. Family involvement was considered very much a work in progress at most sites and the strategies described in this section often relate to ongoing efforts to involve families in collaborative processes.

Participants in this study indicate that family involvement must be actively sought by child-serving agencies. In *East Baltimore*, for example, this meant hiring neighborhood liaisons to visit with families in their homes, to talk with them about the goals of the *East Baltimore Mental Health Partnership* and to encourage family involvement with a family organization called Families Involved Together (FIT). FIT, which receives funding as part of the *East Baltimore Mental Health Partnership*, has encouraged family involvement by locating support groups in the community, holding special parent nights for the Partnership and providing parent training sessions.

Family involvement also means commitment. Respondents in Rhode Island agreed that interagency partners must make such a strong commitment to family involvement that they agree not to have meetings unless parents and other constituency groups are represented. The *PEN-PAL Project* in North Carolina faced a particular challenge to developing family involvement because there was no established family advocacy organization in the counties targeted by the project. Because there was no established local organization, *PEN-PAL* initiated family advocacy through the state mental health office. State-level staff in the *PEN-PAL Project* believe locally generated family advocacy groups would have provided stronger support and better representation of local concerns. Although the existing program has been able to develop a resource center for families and participate in planning and teaching pre-service and in-service courses, it is recognized that there are needs for more advocates, additional funding, increased training for advocates and a more central role at the direct service level. Even with the uneven development of family advocacy in the *PEN-PAL Project*, respondents in North Carolina believe that their local collaborative committees have experienced their greatest successes when families have been most involved in the process.

*KanFocus* has also experienced the uneven involvement of families because agency staff sometimes find it difficult to understand how families can be involved. Respondents in *KanFocus* described a shift in perspective that is occurring in agencies as they discover positive roles for families in collaboration and service system development. A respondent from *KanFocus* commented that family involvement is crucial to affecting change because “parents are willing to take risks.” As families have become more involved in *KanFocus*, they have been seen as increasingly important to developing collaborative processes. A *KanFocus* respondent commented that, traditionally, people thought of child-serving agencies as “the only doorway to services.” With increased family involvement, agencies have begun to realize that parents and caregivers open another important door to services. Acknowledging that families are an important point of access for service makes family involvement in collaborative efforts crucial.

In Stark County, family involvement is both formalized and well-developed. The infrastructure for collaboration in Stark County is the Stark County Family Council, an umbrella agency established by families and child-serving agencies. The Stark County Family Council was created for the purpose of ensuring that the public systems and provider agencies really provide the services families need. Although the family council structure is legislated for all counties in Ohio, a respondent from Ohio Families and Children First commented that Stark County’s family council is distinguished by the fact that it “has evolved into being a family- and community-driven organization.”

The Stark County Family Council is home to *FACES*, a family support organization that uses the slogan, “It’s a simple equation, **F**amily **A**dvocacy + **C**ommunity **E**ducation = **S**upport.” *FACES* connects families to community services, provides education and links families to other families with similar concerns. The Stark County Family Council is also home to Creative Community Options (*CCO*) and the *ACCORD*, both serving as interagency councils with specific goals and purposes. The *ACCORD* consists of middle level managers among child-serving agencies who meet to identify service gaps and service capacity areas for the Family Council so that duplication in services is avoided. The *ACCORD* also reviews and monitors service-related outcome indicators such as residential and psychiatric placements for the Family Council. The *CCO* is responsible for working with families to develop the necessary wraparound services for individual children and families. The *CCO* and *ACCORD* activities are supported through a pool of flexible funds for these purposes.

The executive director of the Stark County Family Council is the parent of a child with special needs and is a family advocate. The Stark County Family Council served as the research team’s point of contact for this study. It is important to note that of the nine sites participating in this study, Stark County was the only site at which a community organization independent of any service-providing agency served as the point

of contact. A service provider in Stark County summarized the importance of the Stark County Family Council and family involvement in collaborative processes by saying, "Parents won't let it [collaboration] die; they make us accountable."

Extending from family involvement, participants in this study identified community involvement as a strategy for sustaining collaborative processes. Community involvement that extends beyond the families who are directly involved in services with their children was identified as an important strategy ensuring that the mission and goals of the collaboration are tied to local issues and concerns.

*Parents won't let it [collaboration] die; they make us accountable.*

In Rhode Island, the Local Coordinating Councils provided a structure for collaboration at the local level. Similarly, Vermont used regional planning processes to reinforce a sense of community and local collaboration that was responsive to different areas of the state. In North Carolina, where the system of care reform was organized at the state level, participants recognized that change at the local level cannot be mandated or forced. Local community involvement has helped shift the focus from compliance to state-level directives to establishing their own processes of collaborative service delivery.



# **Chapter V**

## **The Results of Collaboration**

---

### **INTRODUCTION**

As challenging as it is to build collaborative processes into child-serving systems, the participants in this study developed successful strategies for doing so and they knew “true collaboration” when they experienced it. In spite of the challenges faced by these sites, the Comprehensive Community Mental Health Services for Children and Their Families Program participants were both enthusiastic and optimistic as they described the positive impact of collaboration on their ability to serve children and families.

The results of collaboration that were identified by these sites could be clustered into five categories: 1) improved relationships among child-serving agencies; 2) increased understanding of system of care principles; 3) increased relevance of mental health services; 4) improved service delivery; and 5) improved relationships between families and service providers. These results are discussed below.

### **IMPROVED RELATIONSHIPS AMONG CHILD-SERVING AGENCIES**

The improved relationships among child-serving agencies that were experienced as a result of collaborative efforts at the sites participating in this study could be characterized in three ways. Participants found that interagency partners had more respect for one another. They also found that trust had developed among collaboration members, and that interagency partners had begun sharing both responsibility and decision making in their efforts to plan and implement services.

#### **Increased Respect**

As a result of direct efforts to build collaborative practice, the participants in this study found that collaborative agencies had begun to understand each other, particularly with regard to their shared mission to serve children and families. This ability to understand one another brought about a respect for the work and responsibilities of other agencies as well as a recognition of the roles they play providing services. Respondents report that, as a result of collaboration, people have come to know their counterparts in other agencies and are friendlier with one another, allowing them to work with one another in a more respectful way.

The increased understanding also extended to respect for the limitations or restrictions in service delivery that other agencies might experience as a result of legislated regulations or administrative change and upheaval. This has reduced what several agencies referred to as “finger pointing” or blaming individuals in other agencies for agency policies over which they have little or no control. Improved collaboration has allowed agencies to work together to change or adapt to a situation rather than place blame. For example, when collaborating agencies experience unexpected operational changes resulting from new legislative mandates, budget cuts, or the appointment of a new administrator, their collaborating partners are more inclined to work toward finding a mutual solution than to place blame on the affected agency. In the *KanFocus* program, respondents reported that collaboration had made agencies more respectful of each other’s needs and offered the example that collaborating agencies are more sensitive to the other agencies’ time limitation.

---

*As a result of collaboration, people have come to know their counterparts in other agencies and are friendlier with one another, allowing them to work with one another in a more respectful way.*

---

Respondents in San Mateo County reported that improved collaboration contributed to a decrease in tension among agencies as well as a decrease in the tendency to negatively stereotype other child-serving professions. For example, social workers were less likely to think of all probation officers as “wannabe cops who just want to lock kids up” and probation officers are less likely to characterize social workers as “do-gooders who just don’t get it.”

---

*Improved collaboration has allowed agencies to work together to change or adapt to a situation rather than place blame.*

---

Participants in the *PEN-PAL* program in North Carolina reported that participating agencies have found the collaborative process to be somewhat self-reflective because it prompts collaborative participants to rethink the mission, goals and responsibilities of their own agency with respect to the other agencies they work with. A North Carolina respondent commented, “If people don’t truly understand their own organizational culture [organizational history, strengths and needs] and the culture of the organizations they are collaborating with, then they will have a hard time knowing the points of flexibility necessary for collaboration.”

## Increased Trust

One of the challenges reported by respondents before the implementation of collaborative processes was a lack of trust among child-serving agencies. Respondents in Rhode Island reported that trust among collaborative partners had increased and that even reluctant collaborators had begun to see the value of

collaboration. Increased trust has allowed them to consider new program and service delivery possibilities based on the skills and contributions of multiple agencies that would not have been possible before their collaborative efforts began. Similarly, Ventura reports that collaboration has allowed people to come to know each other and this has led to a mutual trust among child-serving agencies. Ventura County respondents found that their ability to develop new programs increased as people became more comfortable with one another because the trust and emotional support that came from working together balanced the risk that agencies felt in trying new service delivery approaches. *KanFocus* also reported that they experienced an increased willingness to try new approaches to service delivery as collaborative partners built trust among one another.

---

*Even reluctant collaborators had begun to see the value of collaboration.*

---

## Shared Responsibility and Decision Making

Because collaboration has created situations in which agencies do not have to try to solve problems alone, several sites reported a shift from individual or agency-specific provision of services to a shared approach to service delivery. In Rhode Island, for example, respondents found that collaboration created more confidence in the ability to find solutions because it helped people recognize that, when faced with a daunting situation, there is an advantage in not having to solve the problem alone. Similarly, Vermont

---

*Several sites reported a shift from individual or agency-specific provision of services to a shared approach to service delivery.*

---

reported that collaboration and the experience of working together to create new approaches to service delivery has fostered the belief that a solution is possible and that individuals and agencies have developed more confidence in their abilities to solve

problems at the local level. In Vermont, child-serving agencies have begun to see their problems as shared rather than unique to their agency.

Vermont also commented that collaboration has, over time, become an actual work style. Because interagency partners have found collaboration to be rewarding, they have begun to integrate these concepts into their work place to the degree that it is becoming the rule rather than the exception. Respondents in both Ventura County in California and the *PEN-PAL Project* in North Carolina described the shift toward shared responsibility and decision making as a “culture change.” Participants in Ventura commented that collaboration has created a culture of working together that is a part of all the child-serving agencies participating in the collaborative and people have come to believe that their job or promotion depends upon their ability to collaborate well with other child-serving agencies.

## REFRAMING SERVICE DELIVERY THROUGH SYSTEMS OF CARE

Participants in this study report that after exposure to the systems of care philosophy (through the Comprehensive Community Mental Health Services for Children and Their Families Program), interagency collaboration is seen as helpful across the populations of concern for many agencies. Participants in Rhode Island have found that collaborative members are increasingly recognizing that education, child welfare, juvenile justice, and mental health are not separate issues and that they must be integrated to better serve children and families. Participants in the *PEN-PAL Project* report that although the systems of care philosophy was developed in response to children's mental health needs, that systems of care language, that includes concepts such as family friendly and culturally competent services, individualized care and community-based services, is taking root in other child-serving agencies participating in the project.

Participants in this study commented that the commitment to a systems of care philosophy is expanding and being adopted in programs and agencies outside of mental health and in ways that extend beyond the boundaries of the Comprehensive Community Mental Health Services for Children and Their Families Program. For example, in Oregon, the child welfare agency has adopted the system of care principles as part of its training programs. In North Carolina, the county-based child welfare agency has called interagency planning meetings for children who are not part of the *PEN-PAL Project*, and agencies have responded positively by attending and participating in foster care placement planning. And in *East Baltimore*, the police department has observed the successful collaboration in the Mental Health Partnership and has asked for assistance in planning new programs to serve children who are either witnesses to or victims of violence.

---

*The system of care perspective is shifting the focus of service delivery from the individual service provider to the system as a whole.*

---

Stark County, which reports similar experiences of collaborative practice extending beyond the Comprehensive Community Mental Health Services for Children and Their Families Program, summarized the experience by saying that service delivery is being reframed to a systems of care approach. Stark County respondents commented, as did other sites, that the system of care perspective is shifting the focus of service delivery from the individual service provider to the system as a whole and from a focus on "my [the agency's] child" to "our [the community's] child."

## INCREASED RELEVANCE OF MENTAL HEALTH SERVICES

Participants in this study report that collaboration, and particularly the collaboration initiated through mental health agencies by the Comprehensive Community Mental Health Services for Children and Their Families Program, is changing how agencies and families view mental health. Participants in Rhode Island

commented that the Child and Adolescent Service System Program and the system of care approach to service delivery have “dramatically changed the perception of community mental health.” They described this as a shift from the perception of mental health as a small group of very aloof providers to a perception of mental health as a leader in efforts to provide comprehensive community-based services for children and families. Respondents in Ventura County in California describe an old view of mental health as not being responsive to community needs and a new view of mental health as offering relevant services.

*East Baltimore* commented that mental health is now seen as a contributor to the welfare of the community because the mental health agency comes to the table offering to work with other agencies. Because of this approach, mental health is now thought of as more than therapeutic treatment. Stark County respondents commented that there is less stigma associated with mental health diagnoses in the community and that there is an increased appreciation for what mental health can contribute for the well being of the community. San Mateo County respondents agreed that one of the results of collaborative practice is that mental health is no longer defined as the traditional therapeutic hour, but as a part of the community. Similarly, North Carolina reported that mental health is no longer seen as a place, but as a part of the community.

## **CHANGES IN SERVICE DELIVERY**

The sites participating in this study reported specific improvements in service delivery that they believe are a result of collaborative practice. They noted less fragmentation in services, an improved ability to meet specialized needs, more choices in services, improved access to services and improved outcomes for children and families as the most notable changes.

Less fragmentation in services was one of the first improvements in service delivery mentioned by participants in this study. Respondents from San Mateo County in California said that the availability of a pool of funds designated for interagency use created the impetus for a shift in focus away from individual agencies to how services could be designed and delivered for the entire county. This shift resulted in less fragmented services. As one interagency partner commented, the funding for multi-agency services, “is in one pot. I had to let go of *my* [program] and *my* services.” Participants from Stark County also described a reduction in the fragmentation of services as a result of having an interagency council to distribute pooled funds for services to children and families with the most serious issues. In this less fragmented environment, respondents from North Carolina have found that collaborating agencies hold one another accountable to a higher standard of service delivery.

---

*Less fragmentation in services was one of the first improvements in service delivery mentioned by participants in this study.*

---

Participants in this study also found that collaboration has improved the ability of the service system to respond to specialized needs by providing more appropriate service options. For example, Ventura County found that mental health offices working more closely with the child welfare agency resulted in improved diagnostic processes and more appropriate treatment plans for individual children and families.

---

*Collaboration has improved the ability of the service system to respond to specialized needs by providing more appropriate service options.*

---

Because the child welfare agency does not have the resources to provide clinical skills, collaboration processes have provided a valuable resource in serving children with child welfare needs.

Other sites offered examples of how their collaborative efforts had resulted in services that allow them to meet more specialized needs. Rhode Island respondents described a day

treatment program that was designed and implemented by interagency partners. *KanFocus* partners described the establishment of the South East Kansas Academy, that provides educational and mental health services to a five-county area. *East Baltimore* has been able to enhance existing after-school programs by providing a therapeutic tutorial program to meet the needs of children with academic and emotional problems who would not otherwise have after school services. In addition, respondents have observed that increased collaboration has provided a wider array of services and more flexibility in responding to the needs of children and families. San Mateo County in California noted the addition of emergency shelter services for abused and neglected teenagers, in-home intensive services for youth in mental health and probation placements, and the placement of mental health staff in schools as examples of increased flexibility of services resulting from their collaborative efforts.

Respondents have also found that access to services has improved as a result of their collaborative efforts. Because collaboration has put providers from a variety of child-serving agencies in close contact with one another, cross-agency referrals have increased. A San Mateo County respondent commented that if a service provider knows who is on the other side of the phone, he or she is more likely to refer a client to another agency. In addition, Vermont respondents have found that establishing collaborative practice has improved the response time in service delivery and that as a result of collaborative partners being more responsive to one another, services are more often available without a waiting list.

---

*Access to services has improved as a result of their collaborative efforts.*

---

Finally, in regard to improvements in service delivery that have resulted from increased collaboration, respondents believe that children and families have benefited from improved outcomes. For example, a main goal of *Access Vermont* is to reduce the number of children entering state custody. They

found that they have been able to reduce the number of children in state custody significantly since they began building collaborative processes into their service delivery systems. Stark County has found that their interagency collaboration has aided the development of services and supports that have decreased out-of-home placements by 48 percent across child-serving systems. Respondents from this site expressed the belief that collaboration has increased their ability to care for children and families in their community.

## IMPROVED RELATIONSHIPS BETWEEN FAMILIES AND SERVICE PROVIDERS

When services are fragmented and categorical, the needs of children and families are fragmented as well. Every site that participated in this study reported that interagency collaboration had improved their ability to consider the needs of the “whole child and the whole family” within the context of their community. The most significant change noted in this regard is the shift from thinking about children as “mental health kids, social services kids, juvenile justice kids, or special education kids” to child-serving agencies thinking of these children as “our kids.” Respondents from North Carolina described this as a shift in thinking, a shift in action, and a shift in approach to service delivery.

---

*Every site that participated in this study reported that interagency collaboration had improved their ability to consider the needs of the “whole child and the whole family” within the context of their community.*

---

The family members interviewed for this project stressed that the work of establishing stronger and more positive relationships between families and service providers is not complete, but family members from many sites talked about how their involvement in the collaborative process has reduced the degree to which children are categorized by departments and improved service providers’ abilities to consider children holistically. In Stark County, for example, an effort has been made to shift the emphasis of service delivery from the child’s problems to the child and family’s strengths and needs. At Stark County’s Creative Community Options interagency meetings, that provide placement for children most at risk of out-of-home placement, agency representatives and family members work together to develop service delivery strategies for individual children and families. Interagency partners take an active role in brainstorming and determining appropriate placement, regardless of whether the child and family being served are receiving their agency’s services.

Relationships with family members are growing and changing as a result of interagency collaboration. Respondents at *KanFocus* have found that service providers are increasingly aware that it is difficult to help children without involving parents and other care givers positively in the process. Respondents in North Carolina

report that, as a result of the *PEN-PAL Project*, there is increasing recognition that there is a role for families beyond someone to blame. Family members and family advocates are involved in the *PEN-PAL* State Oversight

---

***R****elationships with family members are growing and changing as a result of interagency collaboration.*

---

Committee, the local Project Management Committee and in the Individual Service Teams, that create the individual service plans for individual children and their families.

Family members in *East Baltimore* also reported changing relationships between family members and service providers. Family members' role as advocates for children and families has become more respected by service providers and they have become more integrated into the service delivery process. There is also an increased recognition by families that the training and expertise of service providers is important and necessary. Respondents in *East Baltimore* felt that this growing mutual respect has reduced concerns about the de-professionalization of service delivery while clarifying the roles of both service delivery professionals and family members.

# Chapter VI

## Implications for Building Collaboration

---

### INTRODUCTION

The goal of this *Promising Practice* monograph on interagency collaboration was to learn from the experience of families, service providers, administrators and community members at the Comprehensive Community Mental Health Services for Children and Their Families Program sites regarding their experiences, successes, hopes and concerns for collaborative practice so that others might benefit from their experience. This study of collaboration at nine of these sites offers the opportunity to consider implications for building collaborative processes in other communities that are striving to develop systems of care for children with serious emotional disturbance and their families.

### LESSONS LEARNED

The findings of this study can be summarized in three broad statements about the process of building interagency collaboration. First, collaboration must occur at multiple administrative levels within a child-serving agency and across the agencies that serve children with serious emotional disturbance and their families. To be successful, collaborative practice must be embraced by agency administrators, program directors, and direct service staff. Because building collaboration is a developmental process, it is possible to establish collaboration at one level without achieving collaborative practice at one of the other levels. The sites participating in this study offered multiple strategies for ensuring the establishment of collaborative practice throughout child-serving agencies. These strategies included creating collaborative structures that involve top administrators, others that included middle managers, as well as training efforts directed at building collaboration at the direct service level.

Second, building collaboration is a developmental process. Collaboration is built slowly and with considerable effort, as was reflected in the discussion of strategies for building collaborative practice in this monograph. Collaboration represents a fundamental change in the way services are delivered, and this change is neither smooth nor linear in its development. Participants in this study described the evolution of collaboration as uneven or jagged, with progress sometimes mitigated by unexpected changes such as changes in key personnel or

---

*Collaboration represents a fundamental change in the way services are delivered, and this change is neither smooth nor linear in its development.*

---

funding sources. And, although none felt their work of building collaboration was complete, participants in this study described their successes in advancing collaborative practice and could clearly elaborate on the positive changes they had experienced as a result of their efforts.

Third, the emergence of families as full partners in the service delivery process, both individually in terms of their participation with their own children and collectively in terms of their participation in planning and policy issues, is the key to achieving a true and lasting collaboration.

---

*It was when families had emerged as full partners in the system of care that sites felt they had experienced true collaboration.*

---

Participants in this study described their goal as “true collaboration,” that incorporates qualities of role clarity for families and service providers, interdependence and shared responsibility among collaborating partners, vision-driven solutions, and a focus on the whole child. True collaboration, however, was also perceived as somewhat elusive.

Although some sites had achieved a considerable measure of collaboration among child-serving agencies, they described their greatest successes as those that incorporated families fully into a seamless system of service delivery. It was when families had emerged as full partners in the system of care that sites felt they had experienced true collaboration.

These three lessons learned, the necessity of multi-level involvement in collaborative processes, the developmental nature of collaboration and the full integration of families into the service delivery process, will be discussed in more detail below.

## **Multi-level Involvement in Collaboration**

Well-developed collaborative efforts involve the participation of child-serving agencies at three different levels: at the macro or agency level, the program level, and the provider or direct service level. Each of these levels supports collaboration among agencies in different ways.

Agency-level participation usually involves agency heads in collaborative activity and serves the purpose of ensuring that individual agency policies reflect the vision and mission of collaboration. Program-level collaboration often involves mid-level managers such as program directors in formal collaborative activities. The involvement of program-level staff ensures that collaborative services

---

*Well-developed collaborative efforts involve the participation of child-serving agencies at three different levels: at the macro or agency level, the program level and the provider or direct service level.*

---

for children with serious emotional disturbance and their families are designed and implemented in ways that

can be carried out successfully by the participating agencies. Finally, the involvement of direct service staff ensures that collaboration is established in the context of day-to-day practice and that collaboration is embedded in the actions of the individuals who have the most direct contact with children and their families.

Feedback from the sites participating in this study reinforced the necessity of attending to collaborative development at all three of these levels, and the sites provided examples of strategies that involved each of these levels in building collaborative processes.

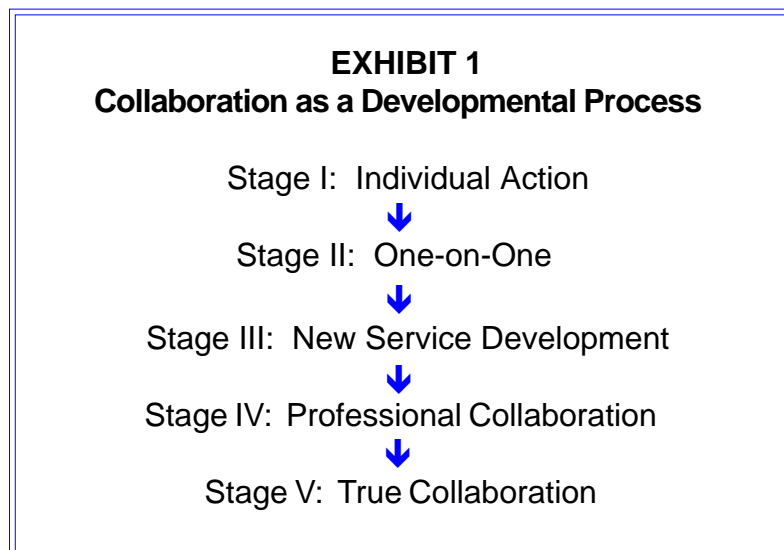
## DEVELOPMENTAL STAGES OF COLLABORATION

As the sites involved in this study described their experiences in building interagency collaboration, five stages of development emerged as characteristic of the process. These stages are shown in the table below.

---

*The stages of collaborative development illustrate a move away from individual action and toward collaborative processes.*

---



The stages of collaborative development illustrate a move away from individual action and toward collaborative processes. Each stage has certain defining characteristics and is associated with certain collaborative activities. The interview data indicate, however, that a site might move unevenly through this process, perhaps not exhibiting all of the defining characteristics of a stage or not engaging in all of the activities of a stage at a particular juncture.

## Individual Action

The stage of individual action can be described as one of internal agency focus and independent action on behalf of children and families. At this early stage of development, there are no specific collaborative activities. However, the sites identified the recognition of the need to change as an important foundational element in promoting collaboration. The catalyst for moving into the next stage of collaborative development is this recognition of the need to change and the potential to do things differently. The defining characteristics and collaborative activities of Stage 1 are shown below.

EXHIBIT 2 DEVELOPMENTAL STAGE 1 Individual Action	
Defining Characteristics	Collaborative Activities
<ul style="list-style-type: none"> <li>Internal agency focus</li> <li>Independent action</li> <li>Categorical funding</li> <li>Fragmented services</li> <li>Different mandates and service philosophies among agencies</li> </ul>	<ul style="list-style-type: none"> <li>Not yet undertaken</li> </ul>
<p>Catalyst for change to next stage: Recognize need to change</p> <p>↓</p>	

## One-on-One


Participants in this study described early efforts toward collaborative practice as often beginning with an individual in one child-serving agency making contact with an individual in another child-serving agency, usually for the purpose of dealing with a specific issue. In spite of categorical funding, fragmented services and significant differences in the mandates and service delivery philosophies of the

---

*This stage of development can result in the emergence of both a core group of potential collaborators willing to pursue collaboration on a larger scale and leaders who will take on the responsibility of pushing the process forward.*

---

agencies, individuals attempt to work toward a solution to a specific problem. This stage of development can result in the emergence of both a core group of potential collaborators willing to pursue collaboration on a larger scale and leaders who will take on the responsibility of pushing the process forward. The catalyst for moving to the next stage of collaboration is the recognition of the potential for collaboration to improve service delivery. The defining characteristics and collaborative activities of Stage 2 are shown below.

<b>EXHIBIT 3</b> <b>DEVELOPMENTAL STAGE 2</b> <b>One-On-One</b>	
Defining Characteristics	Collaborative Activities
<ul style="list-style-type: none"> <li>■ Categorical funding</li> <li>■ Fragmented services</li> <li>■ Different mandates and service philosophies among agencies</li> <li>■ Increased awareness of agency differences in populations served, services provided, agency-specific language</li> </ul>	<ul style="list-style-type: none"> <li>■ Experimentation with one-on-one interagency contact</li> <li>■ Use interagency contact to work on a specific problem</li> </ul>
Catalyst for change to next stage: Recognize potential for collaboration 	

## New Service Development

The third stage of development with respect to collaborative processes can be identified as the New Service Development stage. Participants in this study described this early stage of collaborative activity as involving risk taking and risk sharing among collaborative partners in an effort to develop new ways to deliver services. Participants recommended beginning collaborative efforts strategically by starting small and using the newly developed services as models of successful collaboration. During this stage the sites participating in this study observed a shift from agency-centered thinking about service delivery to a more collaborative approach to providing services. One of the results of this stage of development is the clarification of a vision of collaboration among

---

*One of the results of this stage of development is the clarification of a vision of collaboration among participating agencies.*

---

participating agencies. The catalyst for movement to the next stage of development is the introduction of a formal collaborative structure. The defining characteristics and collaborative activities of Stage 3 are shown below.

<b>EXHIBIT 4 DEVELOPMENTAL STAGE 3 New Service Development</b>	
<b>Defining Characteristics</b>	<b>Collaborative Activities</b>
<ul style="list-style-type: none"> <li>■ Risk taking/risk sharing in order to develop new ways to deliver services</li> <li>■ Increased trust among agencies</li> <li>■ Increased understanding of strengths and limitations of collaborative partners</li> <li>■ Agency personnel have collaborative responsibilities</li> <li>■ Begin shift from agency-centered thinking to collaborative-centered thinking</li> </ul>	<ul style="list-style-type: none"> <li>■ Experiment with new service delivery strategies</li> <li>■ Develop successful collaborative programs to model collaborative behavior</li> <li>■ Experiment with cross-agency placement of personnel</li> <li>■ Training to introduce purpose and mission of collaboration</li> <li>■ Training to assess interagency strengths and differences</li> <li>■ Evaluation and outcome data</li> </ul>
<p>Catalyst for change to next stage: Formal structure introduced</p> <p style="text-align: center;">↓</p>	

## Professional Collaboration

The fourth developmental stage of collaboration can be described in terms of well-developed professional collaborations among child-serving partners. Fully developed, this stage embodies the characteristic of collaboration occurring at the agency level, the program level and the service provider level. Other defining characteristics of this stage include group decision making, established guidelines and procedures and funding for collaborative service delivery. The result of this stage of development is the emergence of a common vision or mission for the collaborative process that is shared among interagency partners. Well-developed interagency collaboration among child-serving agencies is a necessary ingredient to the concept of “true collaboration” described by participants in this study. However, participants in this study indicate that the existence of professional collaboration did not, in itself, provide a truly collaborative environment. As service

---

*Other defining characteristics of this stage include group decision making, established guidelines and procedures and funding for collaborative service delivery.*

---

providers collaborate with one another at the agency, program and provider levels, they have an opportunity to view children being served holistically in the context of their families and communities. Recognizing the importance of seeing children holistically introduces the possibility of an entirely different stage of collaboration, one that integrates families into the process of collaboration. Participants identified the need to view children holistically as the catalyst for moving toward true collaboration. The defining characteristics and collaborative activities of Stage 4 are shown below.

<b>EXHIBIT 5 DEVELOPMENTAL STAGE 4 Professional Collaboration</b>	
<b>Defining Characteristics</b>	<b>Collaborative Activities</b>
<ul style="list-style-type: none"><li>■ Collaboration effective at agency level, program level and practice level</li><li>■ Agreed upon guidelines and procedures for collaboration</li><li>■ Shared responsibility</li><li>■ Group decision making</li><li>■ Pool of collaborative funds</li><li>■ Established collaborative culture (shared vision, goals, language)</li></ul>	<ul style="list-style-type: none"><li>■ Regular meetings of collaborative bodies for purpose of guiding collaborative service delivery and reviewing effectiveness of collaborative processes</li><li>■ Training to reinforce collaborative efforts at all levels of child-serving organizations</li><li>■ Formal interagency agreements</li></ul>
Catalyst for change to next stage: Recognize need to see whole child ↓	

## Families as Full Partners

Just as building interagency collaboration was described as a developmental process by participants in this study, family involvement in systems of care was described as following a developmental path. Participants in this study described family involvement on two levels: 1) the involvement of families in decisions that shape services for their own children, and 2) the involvement of families in decisions that affect the planning and delivery of services in their community. Family involvement in collaborative processes means extending the strategy of shared decision making at both the individual and system level to parents and other caregivers.

---

*Family involvement in collaborative processes means extending the strategy of shared decision making at both the individual and system level to parents and other caregivers.*

---

Family members and professionals both described the process of clearly defining the role of families in the context of collaboration as challenging and sometimes frustrating. The data from this study indicate that family involvement was a negotiated process that occurred over time and could not be mandated either by reserving spaces for family members on collaborative committees and boards or by requiring family signatures on individual service plans.

During interviews for this study, respondents from child-serving agencies talked about how their thoughts on family involvement changed over time. What emerged from these discussions was a developmental process that involved four stages of development. These stages are shown in Exhibit 6 below.



These stages of development illustrate an evolution from viewing family members as outsiders to the service delivery process toward involving families in a collaborative effort, both at an individual and system level. Participants in this study reported that this was an uneven process and that successfully involving families at one level did not assure their involvement at the other. For example, family members could be well integrated into the systems-level collaborative processes through their participation on committees that govern policy and design services without having the ability to participate fully in the decisions that affect the services their individual children were receiving.

The involvement of family members as full partners in the collaborative process was identified as the key ingredient in moving systems of care from the stage of well-developed professional collaboration to the fifth developmental stage of collaboration, the ideal of true collaboration. The defining characteristics and collaborative activities of true collaboration include those identified at the fourth developmental stage of

collaborative development. They are, however, qualitatively different because of the involvement of family members as full partners in the system of care. The defining characteristics unique to true collaboration are shown below.

<b>EXHIBIT 7 DEVELOPMENTAL STAGE 5 True Collaboration</b>	
<b>Defining Characteristics</b>	<b>Collaborative Activities</b>
<ul style="list-style-type: none"><li>■ Families as full partners in service delivery</li><li>■ Role clarity for families and service providers</li><li>■ Broader community involvement in collaboration (extending beyond mental health, child welfare, juvenile justice and education)</li><li>■ Interdependence and shared responsibility among stakeholders</li><li>■ Vision-driven solutions</li></ul>	<ul style="list-style-type: none"><li>■ Include activities of professional stage of collaborative development, but are qualitatively different because of the full partnership of family members</li></ul>

## ACHIEVING TRUE COLLABORATION

The results of this study indicate that while well-developed professional collaboration is a necessary component of true collaboration, it is not sufficient in and of itself. The sites participating in this study related their experiences in building collaborative processes to both the development of strong interagency collaborations and the development of full family participation. These two processes must be fully developed and woven together to achieve the goal of true collaboration.

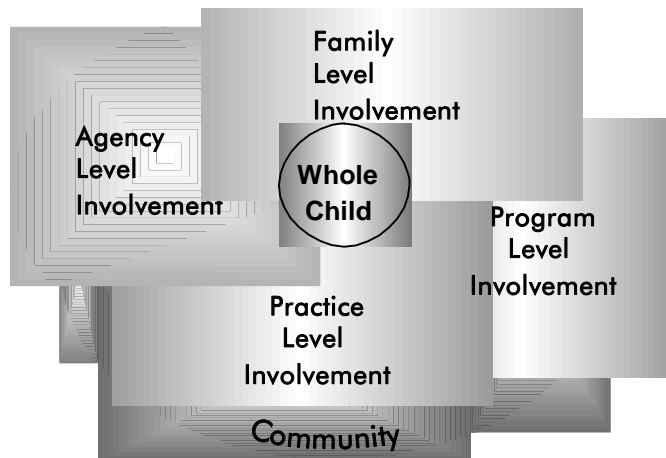
---

*True collaboration results in the ability to focus on the whole child in the context of his or her community.*

---

Four essential components of true collaboration can be identified and are illustrated on the figure below. These include the involvement of child-serving agencies in collaborative processes at the agency, program and practice-levels as well as the involvement of family members as full partners in the system of care. These four essential components unite around the child for the purpose of improving services for children with serious emotional disturbance and their families. True collaboration results in the ability to focus on the whole child in the context of his or her community. In the illustration on the next page, the community is seen as the foundation upon which true collaboration is built.

## Essential Components of True Collaboration



The experiences of the nine sites that participated in this study indicated that timing is important. The earlier the process of family involvement is developed, the more integrated it became in the development of collaborative processes. Sites that attempted to integrate families into collaborative processes after achieving the professional collaboration described in stage four, found full family participation difficult to achieve.

Although respondents talked about their experiences in recognizing the important role families could play in collaborative processes, there seemed to be no single strategy for achieving this goal. Several sites described defining moments during which the importance of family involvement was realized. These moments often occurred in the context of retreats or training sessions focused on nurturing collaborative processes. Frequently, the result of a single comment or observation caused participants to question and reconsider their approach to family involvement.

---

*Several sites described defining moments during which the importance of family involvement was realized.*

---

Regardless of how this recognition occurred, the realization of families as full partners enabled collaborative processes to move forward.

Sites that have begun to involve families fully in their collaborative processes have come to believe that families are the key to sustaining their collaborative efforts. Family involvement at both the individual and system levels ensured that services were built upon the principles of a system of care and offered community-based services that were family-centered and culturally competent. Respondents indicated that family involvement makes the service system accountable. Respondents also indicated that family involvement ensures a constancy and consistency in collaborative efforts regardless of administrative, staff and funding changes that affect all child-serving agencies over time.

There are two important aspects of successfully building collaboration into systems of care that participants in the process must acknowledge. One, that collaboration is developmental in nature, and two, that collaboration must be fostered at multiple levels of child-serving agencies. However, the most important implication of this study is that family involvement holds the key to achieving true and sustainable collaboration in systems of care. As a respondent in North Carolina's *PEN-PAL Project* observed, "Family participation allows the focus on the child to be maintained," adding that "Parent involvement is *THE* component that assures effective collaboration because it provides a point of honesty in collaboration that is otherwise hard to get to."

---

*The most important implication of this study is that family involvement holds the key to achieving true and sustainable collaboration in systems of care.*

---

## Endnotes

1. Stroul, B. A., & Friedman, R. M. (1986). *A system of care for emotionally disturbed children and youth*. Washington, DC: CASSP Technical Assistance Center.
2. Nelson, C.M., & Pearson, C.A. (1991). *Integrating services for children and youth with emotional and behavioral disorders* (p. 7). Reston, VA: The Council for Exceptional Children.
3. Lourie, I.S. (1994). Norfolk, VA. In B.A. Stroul, I.S. Lourie, S.K. Goldman, & J.W. Katz-Leavy, *Profiles of local systems of care for children and adolescents with severe emotional disturbances*. (Revised edition) (pp. 30-31). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
4. Nelson, C.M., & Pearson, C.A. (1991). *Integrating services for children and youth with emotional and behavioral disorders* (p. 39). Reston, VA: The Council for Exceptional Children.
5. Melaville, A.I., & Blank, M.J. (1991). *What it takes: Structuring interagency partnerships to connect children and families with comprehensive services*. Washington, DC: Education and Human Services Consortium.
6. Bruner, C. (1991). *Thinking collaboratively: Ten questions and answers to help policy makers improve children's services*. Washington DC: Education and Human Services Consortium.
7. Melaville, A.I. & Blank, M.J. (1991)
8. Lippitt, R., & Van Til, J. (1981). Can we achieve a collaborative community? Issues, imperatives, potentials. *Journal of Voluntary Action Research*, 10(3-4), 7-17.
9. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991). *The community collaboration manual*. Washington, DC: The National Assembly of Voluntary Health and Social Welfare Organizations.
10. Gates, C. T. (1991, Spring). Making a case for collaborative problem solving. *National Civic Review*, 113-119. See also, Bruner, C. (1991).
11. Gates, C.T. (1991) and The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
12. Gray, B. (1989). *Collaborating: Finding common ground for multiparity problems*. San Francisco: Jossey-Bass Publishers.

13. Abbott, B., Jordan, P., & Murtaza, N. (1993). Interagency collaboration for children's mental health services: The San Mateo County model for managed care. *Administration and Policy in Mental Health*, 22, 301-313.
14. Abbott, et al. (1993).
15. Lourie (1994).
16. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
17. Abbott, et al. (1993).
18. Magrab, P. R., Young, T., & Waddell, A. (1985). *Developing collaborative services for seriously emotionally disturbed children*. Washington, DC: Georgetown University Child Development Center.
19. Rouse, L.W., MacCabe, N. & Toprac, M.G. (1995). *The development of a state-wide continuous evaluation system for the Texas Children's Mental Health Plan: A total quality management approach*. Presentation at the 8th Annual Research Conference for Children's Mental Health, Tampa, Florida.
20. Himmelman, A.T. (1993, July). *Helping each other help others: Principles and practices of collaboration*. ARCH Factsheet Number 25. Washington, DC: ARCH National Resource Center for Crisis Nurseries and Respite Care Services.
21. Lippitt & Van Til (1981).
22. Bruner (1991).
23. Quinn, K. & Cumblad, C. (1994). Service providers' perceptions of interagency collaboration in their communities (p.109). *Journal of Emotional and Behavioral Disorders*, 2(2), 109-116.
24. Himmelman, A.T. (1993, July). *Helping each other help others: Principles and practices of collaboration*. ARCH Factsheet Number 25 (p.1). Washington, DC: ARCH National Resource Center for Crisis Nurseries and Respite Care Services.
25. Bruner (1991).
26. Quinn, K., & Cumblad, C. (1994). Service providers' perceptions of interagency collaboration in their communities. *Journal of Emotional and Behavioral Disorders*, 2(2), 109-116.
27. Gray (1989).
28. The National Network for Collaboration (1995). *Collaboration framework- Addressing community capacity*. Cooperative State Research, Education, and Extension Service, USDA. [Http://www.cyfernet.org/ncco/framework.html](http://www.cyfernet.org/ncco/framework.html).

29. Bruner (1991).
30. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
31. Bruner (1991).
32. Kagan, S.L. (1991). *United we stand: Collaboration for child care and early education services*. New York: Teachers College Press.
33. Bruner, C. (1991); Gray, B. (1989); Magrab, et al. (1985).
34. Bruner, C. (1991); Gray, B. (1989); Magrab, et al. (1985).
35. Stroul, B.A. (1994). Richland County, Ohio. In B.A. Stroul, I.S. Lourie, S.K. Goldman, & J.W. Katz-Leavy, *Profiles of local systems of care for children and adolescents with severe emotional disturbances* (Revised edition) (p. 156). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
36. Gray, B. (1989); Magrab, et al. (1985); The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
37. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
38. Magrab, et al. (1985).
39. Lippitt & Van Til (1981).
40. Gray (1989).
41. Magrab, et al. (1985).
42. Powell, W. W., Koput, K. W., & Smith-Doerr, L. (1996). Interorganizational collaboration and the locus of innovation: Networks of learning in biotechnology. *Administrative Science Quarterly*, 41, 116-145. See also, Magrab, et al. (1985); Himmelman, (1993).
43. Gray (1989).
44. Skiba, R., Polsgrove, L., & Nasstrom, K. (1996). *Developing a system of care: Collaboration for students with emotional/behavioral disorders*. Reston, Virginia: The Council for Children with Behavioral Disorders.
45. Katz-Leavy, J.W., Lourie, I.S., Stroul, B.A., & Zeigler-Dendy, C. (1992). *Individualized services in a system of care*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

46. Mason, J., & Young, T.M. (1990). *Therapeutic case advocacy trainers' guide: A format for training direct service staff and administrators*. (Report No. EC 300 282). Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health. (ERIC Document Reproduction Service Report No. ED 332 420).
47. Skiba, et al. (1996).
48. Jordan, D.D., & Hernandez, M. (1990). The Ventura Planning Model: A proposal for mental health reform. *The Journal for Mental Health Administration*, 17(1), 26-47.
49. Bruner (1991); Quinn & Cumblad (1994).
50. Macbeth, Gary (1993). Collaboration can be elusive: Virginia's experience in developing an interagency system of care. *Administration and Policy in Mental Health*, 20, 259-282.
51. Gans, G.T. & Horton, G.T. (1975). *Integration of human services: The state and municipal levels*. New York: Praeger.
52. Skiba, et al. (1996).
53. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
54. Lourie, I.S. (1994). Norfolk, VA. In B.A. Stroul, I.S. Lourie, S.K. Goldman, & J.W. Katz-Leavy, *Profiles of local systems of care for children and adolescents with severe emotional disturbances*. (Revised edition) (pp. 27-86). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
55. Skiba, et al. (1996).
56. Jordan & Hernandez (1990).
57. VanDenBerg, J. (1989). Alaska youth initiative program background.
58. Catron, T., & Weiss, B. (1994). The Vanderbilt school-based counseling program: An interagency, primary-care model of mental health services. *Journal of Emotional and Behavior Disorders*, 2(4), 247-253.
59. Bruner (1991); Magrab, et al. (1985).
60. Ellmer, R., & Lein, L. (1994). Process evaluation: Texas Children's Mental Health Plan final report. Child Studies Project, The University of Texas at Austin.
61. The National Network for Collaboration (1995).

62. Lippitt & Van Til (1981).
63. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
64. Gray (1989).
65. Skiba, et al. (1996).
66. Skiba, et al. (1996).
67. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
68. Gray (1989); Powell, et al. (1996); Skiba, et al. (1996).
69. Powell, et al. (1996).
70. Gray (1989).
71. Cumblad, C., Epstein, M.H., Keeney, K., Marty, T., & Soderlund, J. (1996). Children and adolescents network: A community-based program to serve individuals with serious emotional disturbance. *Special Services in the Schools*, 11(1-2), 97-118.
72. Skiba, et al. (1996).
73. Byles, J.A. (1985). Problems in interagency collaboration: Lessons from a project that failed. *Child Abuse and Neglect*, 9, 549-554.
74. Skiba, et al. (1996).
75. Gray (1989).
76. Macbeth (1993).
77. Macbeth (1993).
78. Macbeth (1993).
79. Magrab, et al. (1985).
80. Magrab, et al. (1985).
81. Skiba, et al. (1985).

82. Joining Forces, American Public Welfare Association, Center for Law and Social Policy, Council of Chief State School Officers, & Education Commission of States (1992). *Confidentiality and collaboration: Information sharing in interagency efforts*. Denver, CO: Education Commission of the States (ECS) Distribution Center.
83. The National Assembly of National Voluntary Health and Social Welfare Organizations (1991).
84. Macbeth (1993); Magrab, et al. (1985).
85. Skiba, et al. (1996).
86. Magrab, et al. (1985).
87. Gray (1989).
88. Friend, M., & Cook, L. (1990). Collaboration as a predictor for success in school reform. *Journal of Educational and Psychological Consultation* 1(1), 69-86; Goldman, H. & Intriligator, B.A. (1990). *Factors that enhance collaboration among education, health, and social service agencies*. Paper presented at the 1990 Annual Meeting of the American Educational Research Association; Knitzer, J. & Yelton, S. (1990). Collaborations between child welfare and mental health: Both systems must exploit the program possibilities. *Public Welfare*, 48 (Spring), 24-33; Himmelman (1993); Lippitt & Van Til (1981).
89. Peck, J.S., Sheinberg, M., & Akamatsu, N.M. (1995) Forming a consortium: A design for interagency collaboration in the delivery of service following the disclosure of incest. *Family Process*, 34, 287-302.
90. Goldman & Intriligator (1990).
91. Himmelman (1993).
92. Himmelman (1993).
93. Peck, et al. (1995).
94. Friend & Cook (1990).
95. Friend & Cook (1990).
96. Goldman & Intriligator (1990).
97. Lippitt & Van Til (1981).
98. Peck, et al. (1995).
99. Lippitt & Van Til (1981).

100. Goldman & Intriligator (1990); Lippitt & Van Til (1981).
101. The National Network for Collaboration (1995).
102. The National Network for Collaboration (1995).
103. Lippitt & Van Til (1981).
104. Friend & Cook (1990).
105. Friend & Cook (1990).
106. Lippitt & Van Til (1981).
107. Lippitt & Van Til (1981).
108. Harvey, V.S. (1995). Interagency collaboration: Providing a system of care for students. *Special Services in the Schools* 10(1), 165-181; Himmelman (1993); Knitzer & Yelton (1990).
109. Goldman & Intriligator (1990).
110. Cumblad, et al. (1996); Goldman & Intriligator (1990).
111. Friend & Cook (1990).
112. Lippitt & Van Til (1981).
113. Goldman, S.K. (1994). Ventura County, CA. In B.A. Stroul, I.S. Lourie, S.K. Goldman, & J.W. Katz-Leavy, *Profiles of local systems of care for children and adolescents with severe emotional disturbances*. (Revised edition). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.
114. Goldman (1994).
115. Goldman (1994).
116. Nelson, C.M., & Pearson, C.A. (1991). *Integrating services for children and youth with emotional and behavioral disorders*. Reston, VA: The Council for Exceptional Children.

# APPENDICES



# Appendix A

---

## DESCRIPTION OF PARTICIPATING SITES

### East Baltimore Mental Health Partnership

The *East Baltimore Mental Health Partnership* (EBMHP) is located in eastern section of the city of Baltimore, Maryland. The EBMHP was developed by a coalition of state, city and local leaders, with the inclusion of representatives from local family and advocacy groups from its inception. It emphasizes the support and empowerment of families and the community to participate in planning and implementation of services and improving the services infrastructure. Its structure includes an administrative level board that includes city officials, Mayor's office reps, families and community members; agency liaisons, which approve and coordinate referrals for service, facilitate communication & problem-solving, and develop cross-agency training; a Multi-Agency Coordination Committee (MACC) of middle level managers develop protocols for collaborative services and act as a sounding board for collaboration difficulties among line staff; an Integrated Service Planning Team (ISPT) that handles referrals by setting goals, developing and coordinating services and monitoring progress; and a Family Resource Coordination Unit (FRCU), that provides intensive home and community-based services. Services offered through the EBMHP include therapy, wraparound, emergency support services, case management, linkage to community agencies, school based services, family advocacy, respite, day treatment, and outpatient services. The *East Baltimore Mental Health Partnership* served as one of the three in-depth field sites for this study.

### KanFocus: Kansas

*KanFocus* is a pilot program that began in October 1994 and includes 13 counties in Southeast Kansas. It is administered through the *KanFocus* office in Parsons, Kansas and five mental health centers. *KanFocus* originally contracted with Keys for Networking to place staff in each of the five mental health centers for the purpose of linking families to services by participating in service planning, interagency coalition meetings and provider training. In an effort to increase local participation in leadership of parent advocacy and support, a group of regional parents developed a locally run, independent organization, Parent TEAMS, Inc., through the aid of the *KanFocus* grant. Parent TEAMS, Inc. works in collaboration with multiple local agencies to provide parent voice in the system of care and support services to families. Grant funding is supplemented by additional financial support from the regional interagency community coalitions. *KanFocus* accepts referrals from case managers, schools, SRS and other agencies. The goal is to provide "wraparound" integrated support for all family members. Services offered include case

management, attendant care (one-on-one direct supervision and meeting of special needs such as transportation, tutoring, respite care, planned activities, social interactions, role modeling, and classroom supervision), psycho-social groups and adventure-based counseling, home-based family therapy, early intervention and prevention for at-risk children under the age of seven through Project BEFORE (Bridging Empowers Families to Overcome Risks and help children Excel), parent/family advocacy, and parent driven participatory follow-up evaluation. *KanFocus* participated in this study as a telephone interview site.

## **New Opportunities: Oregon**

*New Opportunities* is located in Lane County Child and Adolescent Behavioral Health center. Collateral agencies in the provision of services include Services for Children and Families (SCF), Juvenile Justice Division of Youth Services (DYS), School districts (19 in the county), Medicaid provider agencies, Commission on Children and Families, Healthy Start and Birth to 3 prevention projects, the Community Safety Net (serves families that fall through the cracks), and the Lane County Managed Care program. *New Opportunities* participated in this study as a telephone interview site.

## **PEN-PAL Project: North Carolina**

The *PEN-PAL Project* is located in Pitt and Edgecombe & Nash counties in eastern North Carolina. It is administered by the state Division of Mental Health, Developmental Disabilities, Substance Abuse Services, Child and Family Services Section, in Raleigh, North Carolina. Pitt-Edgecombe-Nash Public Academic Liaison (*PEN-PAL*) was funded through a state-initiated grant proposal to CMHS to establish multi-agency participation in building a community-based system of services and to provide pre-service and in-service training in system of care principles through collaboration with East Carolina University. The *PEN-PAL* structure includes the State Oversight Committee (SOC) with representatives from key agencies and advocacy groups, Project Management Committees (PMC) in Pitt and Edgecombe-Nash, that include supervisory level representatives from child serving agencies, community reps, the project manager and research associates from State office, the Eastern Carolina University pre-service and in-service training program directors, and family advocates. The Social Sciences Training Consortium (SSTC) at East Carolina University includes reps from the College of Arts & Sciences, Psychology, Human Environmental Sciences, Child Development and Family Relations, Nursing, and Social Work and is responsible for designing and implementing the pre-service curriculum. The Eastern Carolina University *PEN-PAL* Resource Center includes faculty from Education, Medicine, Child & Adolescent Psychology, and Parents in Residence and is responsible for in-service training. *PEN-PAL* has developed a case

management training manual, pre-service training curriculum, in-service training and technical assistance for implementation of system of care principles, field placement of university students trained in SOC, Parents in Residence model that includes parents as partners in development, delivery and evaluation of pre-service and in-service training curricula, training and support for family members (through *WE CARE- With Every Child and Adult Reaching Success*), a local agency asset assessment protocol, quality improvement testing and outcome tracking, System of Care Protocol assessments, and a Service Testing protocol to test system performance. The *PEN-PAL* Program served as one of the three in-depth field sites for this study.

## **Rhode Island: Project REACH**

The State of Rhode Island has established a statewide initiative called *Project REACH* through the Rhode Island Department for Children, Youth and Families. The state office contracts with Local Coordinating Councils in the nine mental health center catchment areas, with offices located in local community mental health center facilities except one that is in a non-profit settlement house. The goal of *Project REACH* is to provide a full continuum of services in a flexible model that is child/family driven and community based, culturally competent, and with multi-agency collaboration including public and private levels. Its structure includes Local Coordinating Councils (LCC) that meet monthly to address system level/community level issues, Family Service Coordinators (FSC) who respond to referrals and schedule case review meetings, and Case Review Teams that develop Individual Service Plans. Services offered include respite, wraparound services, therapeutic recreational services, Children's Intensive Services (CIS) therapy through community Mental Health centers, Day Treatment in schools, and Therapeutic Foster Care. Project Reach participated in this study as a telephone interview site.

## **San Mateo Child and Youth System of Care**

San Mateo County provides a county wide system of care that began as a state funded pilot project for innovation and collaboration in mental health services for children. Its goal is to help children and youth stay in the least restrictive environment, achieve low recidivism for probation youth, and increase school attendance and achievement. Its structure includes a Children's Executive Council that meets six times per year to make policy decisions, chaired by a member of board of supervisors, and including county manager, heads of county departments, superintendent of schools; the Children's Executive Council Action Team (CECAT), an implementation committee to carry out policies of the CEC made up of senior program managers from county departments and private community agencies that meets monthly to identifies gaps, designs programs, generates resources, and focus on long-range collaboration issues; a Child and Youth System of Care committee (CYSOC) which addresses collaboration planning and reform, but that is

currently merging with CECAT; a Case Assistance Committee, made up of staff representatives from the four agencies and a Family Partners Team representative, who meet weekly to discuss progress on difficult cases and to generate new service strategies; and an Interagency Placement Review Board made up of supervisors from agencies that review cases recommended by direct service workers for out-of-home placement. Services offered include a Placement Intervention Program (PIP) with Mental Health and Probation, Intensive in-home counseling (Crossroads), evaluation and crisis intervention (Juvenile Hall), Day treatment, Therapeutic day school, school-based mental health teams, wraparound services, specialized assessments in schools, therapeutic foster care, family partnership services and shelter care teams. The San Mateo Child and Youth System of Care participated in this study as a telephone interview site.

## **Stark County Family Council**

The Stark County Family Council is located in Stark County, Ohio. It has a governing structure created by collaborative partners and families to provide the community with a unified human services infrastructure that provides what families need (through wraparound services) and builds on their strengths. The goal is to nurture and encourage the development of a unified service system that collaborates with families and pools resources, brings resources to the community, develops new services and/or redirecting old services, and provides a forum for collaborative planning and implementation of services. The Stark Family Council structure includes a board of trustees made up of top executive levels of collateral agencies, who appoints the executive director of the Council; working councils to address communications, community violence, cultural competence, managed care, operations, and early childhood issues; Creative Community Options (CCO) treatment planning meetings to develop wraparound services; middle level manager meetings (ACCORD) to review and monitor decisions about services including gaps and duplications, to develop outcome indicators and to cut through bureaucracy; and membership of 220 public and non-profit agencies, religious organizations, parent organizations and fund raising organizations. Services offered through contracts with agencies include treatment foster care, family resource centers, early intervention and prevention programs, family advocacy, community education and support (FACES), a transitional home, mobile crisis response, parenting training, respite care, sex offenders treatment services, and teen pregnancy programs. The Stark County Family Council served as one of the three in-depth field sites for this study.

## **Ventura County Children's Mental Health**

Ventura County provides a county wide system of care in Ventura County, California. It began as a state funded pilot project for innovation and collaboration in mental health services for children with the goal

of keeping children at home, in school and out of trouble by increasing multi-cultural sensitivity of staff, providing a continuum of services, placing children in least restrictive environment, and improving inter-agency staff cooperation. The structure of Ventura county's system of care includes oversight by the County Board of Supervisors; an Interagency Policy Council with agency department and heads of non-profits that meet monthly to master plan and make recommendations to the County Board of Supervisors, to write grants and review proposals from new providers; an SED sub-committee of the SELPA, that evaluates needs and resources; and an Interagency Case management Council made up of line supervisors, which supervises cases. Services offered include Colston collaborative program between probation, mental health and schools; Phoenix, an interagency day treatment program; case management with most kids in placement; and case workers in classrooms and involved with the IEP process. Collateral agencies for mental health include Special Education Local Planning Areas (SELPA), Child Protective Services (CPS) and Probation. Ventura County Children's Mental Health participated in this study as a telephone interview site.

## **Vermont: Access Vermont**

The State of Vermont has created a statewide initiative for providing services to children with serious emotional disturbances and their families that is called *Access Vermont*. *Access Vermont* is administered by the Vermont Agency of Human Services, Department of Developmental & Mental Health Services. The State Department of Developmental and Mental Health Services in collaboration with the State Department of Social and Rehabilitation Services required Local Interagency Teams (Act 264 mandated bodies) to develop Regional *Access Vermont*/Family Preservation Plans with input from service providers, parents and community members. Strategies to be used included bringing new partners into local systems of care, offering new service funds for collaborative planning, identification of outcomes, evaluation data feedback, training opportunities and technical assistance provided by the State Outreach Team. The specific goal of *Access Vermont* was to reduce the number and rate of children unnecessarily entering State custody, especially on emergency detention orders. The structure for the initiative includes an Interagency State Team that oversees regional planning and provides ongoing, on-site technical assistance through the outreach team, and Local Interagency Teams in each of the twelve Agency of Human Services districts. Services offered include interagency case reviews that require parent representation, crisis outreach, intensive in-home services, shelters and other temporary respite, short-term follow-up, and flexible funding to meet the diverse needs of those in crisis. *Access Vermont* participated in this study as a telephone interview site.



# Appendix B

---

## METHODS

### Introduction

The purpose of this *Promising Practices* project was to learn from the experience of service providers, administrators, families, and community members involved in the Comprehensive Community Mental Health Services grant sites as it related to their efforts to establish collaborative practice in their service delivery systems. The goal of this project was to understand how close collaboration between agencies and systems in planning, programming, funding, accountability, and leadership can improve services to children with serious emotional disturbance. Five questions guided this research:

1. What are the components of strong and effective collaboration?
2. What structural and relational factors contribute to increased collaboration?
3. How has increased collaboration changed service to children and families?
4. What supports and impediments have been experienced in building collaboration?
5. Has collaboration changed the way stakeholders perceive children's mental health?

Data collection for this study took place over a six month period during which nine sites were chosen from among the original 22 Center for Mental Health Services (CMHS) grant recipients. Semi-structured interviews based on the five guiding research questions were conducted either in-person or over the telephone with people identified as key participants in the collaboration process at each site. The following is a brief description of the research process to help readers understand how the information in this monograph was gathered and analyzed.

### How were sites chosen?

Nine sites were selected from among the 22 sites originally funded in 1993 by CMHS for the purpose of developing a broad array of community-based and family-focused services for children with serious emotional, behavioral, or mental disorders. The participation of the sites and individuals within the sites in this study was voluntary. The first step in selecting sites was presenting the goals of the *Promising Practices* Initiative to the CMHS grantees at a December 1997

Comprehensive Community Mental Health Services for Children and Their Families Program Project Directors' meeting. At that time, each of the 22 sites was invited to participate in the *Promising Practices* studies. In addition, the Hub Directors, who provide technical assistance and support for the CMHS sites were asked to identify the sites they believed had established strong collaborative practices. Nine sites were identified through this process. Three of these sites, the *PEN-PAL Project* in North Carolina, Stark County Ohio, and the *East Baltimore Mental Health Partnership*, were invited to participate as field-visit sites for more in-depth locally-based interviews. Six sites, Ventura and San Mateo Counties in California, Oregon, Rhode Island, Vermont, and *KanFocus* in Kansas, were invited to participate in telephone interviews. Site coordinators at these sites were then contacted by letter and phone to identify specific strategies and components of collaboration they found to be most important at their sites and to identify key people who should be included in our interviews.

## **How were the interview respondents selected and interviewed?**

Key people to be interviewed were first identified through a telephone conversation with project coordinators. Researchers asked the project coordinators at each site who they thought could best discuss the success and difficulties associated with building collaborative processes in their system of care. Potential participants included mental health program managers, administrators and direct service staff, staff from other child serving agencies, and family members. Interviews were conducted with both individuals and groups either in-person during the site visits or by telephone. Respondents at each site were asked if there were other individuals that they believed would offer an important perspective on collaborative processes and these additional interviews were conducted both in person and by phone whenever possible.

A total of 98 people were interviewed for this project. The guiding research questions were used as a platform for all of the interviews, but the order and emphasis of topics and the direction of the conversation were different for each person. This semi-structured approach to the interviews allowed for the possibility of uncovering new information and important points that other respondents or the researchers might not have been aware of. Interviews were taped, with respondents' permission, and detailed notes and descriptions were written by each interviewer.

## **How were the interviews analyzed for important findings?**

The interviews were summarized for each site and organized into five sections: Foundations, Strategies, Results, Quotations and Next Steps. The Foundations summarized important elements upon which collaboration at the site was built. The strategies section summarized active and explicit efforts employed at that site to build collaboration. The results summarized what was found to be the

important effects of collaboration in the system of care. In addition, issues and concerns for the future were identified in the Next Steps section and quotes highlighting the main interview points were included in the Quotations section. The site summaries were used for the purpose of cross-site comparisons in analyzing the results and identifying themes and patterns in the data.

Data collection and analysis for this project were strengthened by a process of feedback and validation involving the nine sites that participated in this study. The site summaries for each site were returned to the key informant from that site with the request that he or she circulate the summaries among interview participants for the purpose of gathering site specific feedback. The response to this process provided specific clarification and corrections to the site information that was then incorporated into the monograph.

The monograph is organized in a format similar to the site summaries with the findings divided into sections focused on the foundations for collaboration, strategies for collaboration, and results of collaboration.



# Appendix C

---

## GLOSSARY OF TERMS

**CASSP-** the Child and Adolescent Service System Program, a federal program supporting the development of interagency efforts to improve the systems under which the most troubled children and youth receive services. CASSP principles state that services are to be community-base, child and family-centered, culturally competent, and promote coordination among child serving agencies.

**Children with Serious Emotional Disturbance-** young people whose problems are so severe that they require the long-term intervention of mental health and other agencies.

**Comprehensive Community Mental Health Services for Children and Their Families Program** – grant funds provided to states, communities and Indian tribes, and administered by the federal Center for Mental Health Services (CMHS) within the substance Abuse and Mental Health Services Administration (SAMHSA). This was initiated in 1992 to assist in developing service delivery systems that are built on the principles of the Child and Adolescent Service System Program (CASSP) through a system of care approach.

**Collaboration-** the process of bringing together those who have a stake in children's mental health for the purpose of interdependent problem solving that focuses on improving services to children and families. See True Collaboration.

**Coordination-** sharing resources and leadership to provide services, while maintaining individual agency roles, responsibilities and agendas.

**Cultural competence-** a set of behaviors, attitudes and policies of a system, agency or among professionals that enables them to work effectively in cross-cultural situations.

**Day treatment-** the most intensive of non-residential services that can occur for longer periods of time, providing an integrated set of education, counseling and family interventions.

**Integration of services-** providing services in a community through multiple agencies with decreased overlap and decreased gaps in services.

**Interagency collaboration-** the combined, coordinated, cooperative and interdependent efforts of multiple child-serving agencies to provide services that meet the specific needs of children and their families.

**Interagency cooperative agreement** (memorandum of understanding)- written commitments signed by agencies that spell out standards for services (who does what to whom, when, where, how often, under whose supervision, and to whose advantage), or allocation of resources, or procedures, forms and activities, or all of the above.

**Medical model of services-** views the child and the family as the source of the problem and interventions as correction of symptoms by an expert professional.

**Out-of-home placement-**services that require the child to live away from home and possibly outside of the community in order to receive services. This would include residential placements in juvenile justice, child welfare, special education and mental health.

**Outcome accountability-** responsibility on the part of systems of care for accomplishing publicly articulated and accurately tracked goals regarding the services they provide children and their families.

**Outcome-** the impact or results of services provided for children and their families.

**True Collaboration-** successful collaboration within systems of care for children with serious emotional disturbance and their families that incorporates qualities of role clarity for families and service providers, interdependence and shared responsibility among collaborating partners, striving for vision-driven solutions, and a focus on the whole child in the context of the child's family and community.

**System of care-** a philosophy about the way services should be provided for children and families that is founded on the principle that care should be provided that is child-centered (driven by the needs of the child and family) and community-based (provided in less restrictive settings within or near a child's home community). This approach provides for a comprehensive spectrum of mental health and other support services (including education, child welfare, and juvenile justice) organized into a collaborative network to meet the multiple changing needs of children, adolescents and their families.

**Wraparound-** the delivery of coordinated interdisciplinary services provided with the input of the child and family and tailored to the strengths and needs of the individual child and family.



